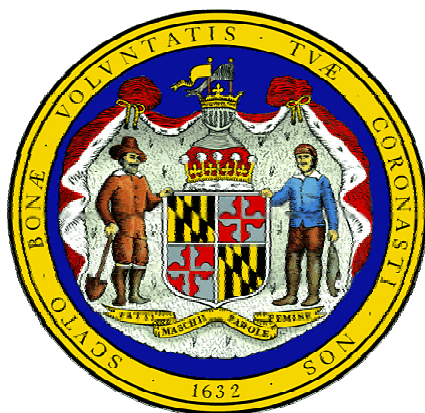


# **An Analysis and Evaluation of Certificate of Need Regulation in Maryland**

## **Working Paper: Rehabilitation Hospital and Chronic Hospital Services**



### **MARYLAND HEALTH CARE COMMISSION**

#### **Division of Health Resources**

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**May 17, 2001**

Donald E. Wilson, M.D., MACP  
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Barbara G. McLean  
Interim Executive Director

## INTRODUCTION

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### ***A. Purpose of the Working Paper***

Through House Bill 995<sup>1</sup>, Maryland's General Assembly has required that the Maryland Health Care Commission ("MHCC" or the "Commission") examine the major policy issues of the Certificate of Need ("CON") review process. On January 1, 2000, the Commission submitted a report to the General Assembly providing a detailed work plan for examining the CON process in Maryland.<sup>2</sup> The CON study work plan submitted to the General Assembly set out specific services for in-depth study over a two-year period, 2000-2001. In calendar year 2000, the Commission analyzed and evaluated Certificate of Need regulation in Maryland for the following health care services: acute inpatient obstetric services, cardiac surgery and therapeutic catheterization services, home health services, hospice services, and nursing home services. A final report providing the Commission's recommendations on these services was submitted to the General Assembly on January 2001.<sup>3</sup>

This working paper is one in a series of working papers that the Commission will be releasing Phase II of the two-year study period that will examine specific issues and implications for changes to the CON model of regulation. The purpose of this report is to examine the current CON policy and regulatory issues affecting rehabilitation hospital and chronic hospital services in Maryland, and to outline several alternative options for changes to the Certificate of Need program and their potential implications. Rehabilitation hospital services and chronic hospital services are types of services defined in health planning statute (Health General Article 19-123(a)) that requires a Certificate of Need to establish, and in some cases, to expand.

### ***B. Invitation for Public Comment***

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than the close of business Friday, June 15, 2001 to:

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<sup>1</sup> Chapter 702, Acts of 1999

<sup>2</sup> Maryland Health Care Commission, *Reports Required Under Section 11 of House Bill 995 (1999)-Health Care Regulatory Reform-Commission Consolidation, Part II*, Work Plan for Examining the Certificate of Need Process: Preliminary Report, January 1, 2000.

<sup>3</sup> Maryland Health Care Commission, *An Analysis and Evaluation of Certificate of need Regulation in Maryland: Phase I Final Report to the Maryland General Assembly*, January 1, 2001.

### ***C. Organization of the Working Paper***

This paper is organized in six major sections. Following this introduction, Part II of the paper is divided into two subsections, containing overviews of rehabilitation hospital and chronic hospital services, including definitions of these services, inventories of existing providers, and data on utilization trends. These sub-sections also discuss alternatives to and trends in rehabilitation hospital and chronic hospital care, reimbursement issues facing rehabilitation hospitals and chronic hospitals, and issues related to quality of care and access to care. Part III describes the functions of the federal and state government agencies with an interest in, or related to their authority over, activities in rehabilitation hospitals and chronic hospitals. Part IV compares Maryland Certificate of Need regulation to what other states are doing with regard to regulating rehabilitation hospitals and chronic hospitals. Part V of the paper, divided into subsections for rehabilitation hospital and chronic hospital services, outlines alternative regulatory strategies for the Certificate of Need program that reflect different assumptions about the role of government regulatory agencies and the role of the market place in protecting the public interest. A summary table, illustrating the alternative options to CON regulation for these two services discussed in this working paper is provided in Part VI.

## II. Maryland Rehabilitation Hospitals: An Overview

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### A. *Rehabilitation Hospitals*

#### 1. Definition

Under §19-318 of the Health-General Article, a license classifying a hospital as a special rehabilitation hospital is required before the hospital may provide, or hold itself out as providing, comprehensive physical rehabilitation services. Such facilities may provide specialized programs for pediatric patients or for persons with brain injuries or spinal cord injuries. Under Maryland law, those rehabilitation programs must be accredited by the CARF...The Rehabilitation Accreditation Commission, formerly the Commission on Accreditation of Rehabilitation Facilities<sup>4</sup>

Acute inpatient rehabilitation services, whether provided in the setting of a hospital or a distinct unit, provide an intense program of coordinated and integrated medical and rehabilitative care. The practitioners who comprise the interdisciplinary team have special training and experience in evaluating, diagnosing, and treating persons with limited function as a consequence of diseases, injuries, impairments, or disabilities. Further, acute inpatient rehabilitation care is provided to patients who are at high risk of potential medical instability, have a potential for needing skilled nursing care of a high medical acuity, and require a coordination of services, level of intensity and setting as follows:

- (a) Regular, direct individual contact by a physiatrist or physician of equivalent training and/or experience in rehabilitation who serves as their lead provider;
- (b) Daily rehabilitation nursing for multiple and/or complex needs;
- (c) A minimum of three hours of physical or occupational therapy per day, at least five days per week, in addition to therapies or services from a psychologist, a social worker, a speech-language pathologist, and a therapeutic recreation specialist, as determined by their individual needs; and
- (d) Based on their individual needs, other services provided in a health care facility that is licensed as a hospital<sup>5</sup>.

The general threshold of the Health Care Financing Administration (“HCFA”) for establishing the need for intensive rehabilitation in a hospital inpatient setting is at least three hours a day of physical and/or occupational therapy. As explained in memoranda designed to transmit additional information about its rules, HCFA allows exceptions to that guideline;

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<sup>4</sup> COMAR 10.24.01, p.4.

<sup>5</sup> COMAR 10.24.09E(1); A hospital is defined as any nonfederal facility in Maryland with one or more beds licensed for acute general or special care, as defined in Health General Article, §19-301(g) and §19-307(a)(1)(i) and (iii), Annotated Code of Maryland.

however, the claim must be documented and reviewed “to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed.”

Over the last decade, hospitals and skilled nursing facilities have developed “subacute” units that admit patients who do not require, or cannot tolerate, intensive rehabilitation services. This larger context raises important questions about the extent of similarities or differences in patients, services, and outcomes among such units and inpatient rehabilitation facilities. According to HCFA, both types of providers have reported an increase in the number of secondary medical conditions and clinical complexities for patients admitted primarily for rehabilitative services, resulting in an overlap of patient populations.

The implementation of a prospective payment system (“PPS”) for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or unit (discussed later in this Working Paper) is expected to improve the data available to HCFA through which to compare patients and monitor care across the different institutional settings. Policies instituted under the PPS for those facilities are likely to have an impact on the admission and review of patients who may not be able to tolerate, or do not receive, intense inpatient therapy services<sup>6</sup>.

In Maryland, the Commission recognizes that increased competition for patients with health insurance, development of networks of health care providers, sub-specialization among health care professionals, and diffusion of technology have resulted in an escalation in the level of care provided by some health care facilities, which may conflict with public policy concerning regionalization of health care services such as inpatient rehabilitation. The Commission has further recognized that the resources for providing health care are limited, and it promotes using those resources in ways that have the greatest potential to improve the health status of Marylanders while containing total system costs. The key values represented in the Commission’s health planning principles emphasize matching the major health problems of the population to effective interventions; integrating levels of care within the regional delivery system; balancing optimal health outcomes and cost-efficiency; and achieving equity in terms of reasonable access to services and assurance of quality.<sup>7</sup>

## **2. Supply and Distribution of Rehabilitation Hospitals in Maryland**

The State Health Plan designates five regional service areas for the planning of acute inpatient rehabilitation services: Eastern Shore, comprised of Cecil, Kent, Queen Anne’s, Talbot, Caroline, Dorchester, Worcester, Wicomico, and Somerset Counties; Southern Maryland, comprised of Prince George’s, Charles, Calvert, and St. Mary’s Counties; Montgomery County; Central Maryland, comprised of Baltimore City and Harford, Baltimore, Anne Arundel, and Howard Counties; and Western Maryland, comprised of Carroll, Frederick, Washington, Allegany, and Garrett Counties.

For some perspective on Maryland’s rehabilitation hospital bed capacity, it is useful to look at the supply, distribution, and programs as displayed in Table 1 and Table 2 on the

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<sup>6</sup> Final Action on Proposed Amendments to COMAR 10.24.09 State Health Plan: Specialized Health Care Services – Acute Inpatient Rehabilitation, March 5, 2001, p. 2.

<sup>7</sup> COMAR 10.24.09, page 5

following pages. Table 1 presents the number of rehabilitation beds, patient days, and percent occupancy by facility in Maryland based on 1999 data, the latest available. Table 2 presents a listing of the licensed rehabilitation hospitals in Maryland that have programs accredited by CARF...The Rehabilitation Accreditation Commission.

**Table 1**  
**Number of Rehabilitation Beds and Patient Days and Percent Occupancy,**  
**By Facility: Maryland 1999<sup>8</sup>**

Health Service Area and Facility	Number of Beds	Number of Days	Occupancy (%)
<b><u>Western Maryland</u></b>			
Memorial Hospital of Cumberland	21	1,847	24.1
Washington County Hospital	28	4,942	48.4
<b><u>Montgomery County</u></b>			
Adventist Rehabilitation Hospital <sup>9</sup>	22	1,583	19.7
<b><u>Southern Maryland</u></b>			
Laurel Regional Hospital <sup>10</sup>	16	5,559	116.7
<b><u>Central Maryland</u></b>			
Good Samaritan Hospital <sup>11</sup>	51	13,872	74.5
Johns Hopkins Bayview Medical Center	4	862	59.0
Johns Hopkins Hospital	14	3,321	65.0
Kennedy Krieger Institute	31	7,182	63.5
Kernan Hospital	98	24,711	69.1
Levindale Hebrew Geriatric Center and Hospital	16	3,950	67.6
Maryland General Hospital	33	8,519	70.7
Mt. Washington Pediatric Hospital	46	5,703	34.0
Sinai Hospital of Baltimore	57	12,377	59.5
The New Children's Hospital <sup>12</sup>	18	80	4.9
Union Memorial Hospital <sup>13</sup>	18	3,744	57.0
<b><u>Eastern Shore</u></b>			
HealthSouth Chesapeake Rehabilitation Hospital	44	13,598	84.7

<sup>8</sup> Source: Maryland Health Care Commission (based on licensing information provided by the Office of Health Care Quality; the Uniform Discharge Abstract Data set reported by hospitals to the Health Services Cost Review Commission ("HSCRC"); Hospital Quarterly Reports submitted to the HSCRC by Levindale Hebrew Geriatric Center and Hospital; and annual data reported by Kennedy Krieger Institute and Johns Hopkins Bayview Medical Center to the Maryland Health Care Commission for calendar year 1999).

Notes: Except where noted otherwise, data on patient days were collected using the abstracts of discharge records. Discharge abstracts in which the nature of admission was coded as rehabilitation were included. This category is defined as patients who were admitted for rehabilitative care in a distinct rehabilitation unit. Regulations require that an on-site transfer from an acute care unit to a distinct rehabilitation unit shall be represented by two separate abstracts, one for each portion of the hospital stay.

<sup>9</sup> Change of ownership and name of HealthSouth Rehabilitation Center of Maryland to Adventist Rehabilitation Hospital became effective March 15, 1999. On April 11, 1995, the Maryland Health Resources Planning Commission ("MHRPC"), predecessor to the Maryland Health Care Commission, approved a Certificate of Need for the establishment of a 55-bed rehabilitation hospital on the campus of Shady Grove Adventist Hospital. On January 3, 2001 the MHCC issued a Pre-Licensing Certification for this 55-bed rehabilitation hospital known as Kessler-Adventist Rehabilitation Hospital, and the facility admitted its first patients.

<sup>10</sup> On August 4, 1999, the inpatient rehabilitation capacity of Laurel Regional Hospital increased from 11 to 16 licensed beds.

<sup>11</sup> The number of patient days was estimated by applying the average length of stay of discharges coded as DRG 462 (Rehabilitation) to the number of discharges for which the nature of admission was coded as rehabilitation.

<sup>12</sup> Inpatient services at The New Children's Hospital ended in March 1999, and the hospital closed in May 1999.

<sup>13</sup> The number of patient days was estimated by applying the average length of stay of discharges coded as DRG 462 (Rehabilitation) to the number of discharges for which the nature of admission was coded as rehabilitation.

**Table 2**  
**Licensed Special Rehabilitation Hospitals with Inpatient Programs Accredited by**  
**CARF...The Rehabilitation Accreditation Commission:**  
**Maryland, September 2000<sup>14</sup>**

<b>Hospital</b>	<b>Program<sup>15</sup></b>	<b>Status of Accreditation by CARF—Date of expiration</b>
Good Samaritan Hospital	CIIRP, SCRSC	April 2001
HealthSouth Chesapeake Rehabilitation Hospital	CIIRP	November 2002
Johns Hopkins Bayview Medical Center	CIIRP	November 2001
Johns Hopkins Hospital	CIIRP	April 2003
Kennedy Krieger Institute	CIIRP/PFC, BI/BFC	February 2002
Kernan Hospital	CIIRP, SCRSC, BI	April 2002
Laurel Regional Hospital	CIIRP	December 2001
Levindale Hebrew Geriatric Center and Hospital	CIIRP	March 2002
Maryland General Hospital	CIIRP, BI	December 2001
Memorial Hospital of Cumberland	CIIRP	January 2003
Mt. Washington Pediatric Hospital	CIIRP/PEC	November 2002
Shady Grove Adventist Rehabilitation Hospital <sup>16</sup>	CIIRP	October 2002
Sinai Hospital of Maryland	CIIRP, BI	April 2001
Union Memorial Hospital	CIIRP	March 2001
Washington County Hospital	CIIRP	November 2003

<sup>14</sup> Source: Maryland Health Care Commission from information provided by CARF...The Rehabilitation Accreditation Commission, September 15, 2000

Notes: Deaton Specialty Hospital and Home has CARF-accredited, hospital-based inpatient programs for Comprehensive Integrated Inpatient Rehabilitation and Brain Injury (accreditation through September 2001); however, the hospital does not have licensed rehabilitation beds.

<sup>15</sup> The *1999 Medial Rehabilitation Standards Manual* uses the following codes to identify the type of program: CIIRP = Comprehensive Integrated Inpatient Rehabilitation Program (A = acute, defined as hospital-based); SCRSC = Spinal Cord Rehabilitation System of Care (core is provided only in an acute CIIRP in an organization licensed as a hospital and in its outpatient programs); BI = Brain Injury Programs (BICIP = Brain Injury Comprehensive Inpatient Program; Category One: Hospital; Category Two: Hospital, Hospital-Based Skilled Nursing Facility, Skilled Nursing Facility; Category Three: Hospital-Based Skilled Nursing Facility, Skilled Nursing Facility); and PFC = Pediatric Family-Centered Rehabilitation Programs.

<sup>16</sup> The name of Eastern Neuro Rehabilitation Hospital changed to HealthSouth Rehabilitation Center of Maryland in October 1997; the ownership and name of HealthSouth Rehabilitation Center of Maryland changed to Adventist Rehabilitation Hospital in March 1999. The facility is listed as Adventist Healthcare Rehabilitation Hospital in the CARF database; during its most recent survey, the hospital changed the focus of its accreditation from Brain Injury to Comprehensive Integrated Inpatient Rehabilitation.



### **3. Trends in the Utilization of Maryland's Rehabilitation Hospital Services**

### **4. Reimbursement Issues**

On November 2, 2000, the federal Health Care Financing Administration ("HCFA") released its notice of proposed rulemaking for its inpatient rehabilitation facilities prospective payment system or PPS. This extension of the PPS to rehabilitation hospitals, required by the Balanced Budget Act of 1997 ("BBA"), is designed to promote quality and efficient care at approximately 1,100 inpatient rehabilitation facilities nationwide, including both freestanding hospitals and special units in acute care hospitals. The rule, published in the November 3, 2000 *Federal Register*, included a public comment period which closed February 1, 2001. Medicare has paid acute care hospitals under a prospective payment system since 1983<sup>17</sup>. Rehabilitation facilities, which provide extensive occupational, physical, and speech therapy services, had been exempt from that system. The BBA required HCFA to implement a prospective payment system specifically for rehabilitation facilities.

One of the key features of the PPS is that it will re-distribute the total amount of Medicare payments to rehabilitation facilities. Under the proposal, rehabilitation facilities will be paid based on the characteristics of each individual patient whom they admit. Medicare will pay hospitals more to care for patients with greater needs, as determined by a comprehensive assessment of their condition. The prospective payment system will replace the existing cost-based payment system, according to the following principles:

- Rehabilitation facilities will be paid on a per-discharge basis just as acute care hospitals are paid. Medicare prospective payments will cover all the costs of furnishing covered inpatient rehabilitation services – including routine, ancillary, and capital costs – except for bad debt and certain other costs, which will be paid for separately.
- Medicare will pay facilities at relatively higher rates to care for patients with more intensive needs. Payment rates will reflect each patient's rehabilitation conditions, functional status (both motor and cognitive), age, related illnesses, and other factors that help to explain the intensity of care required by different patients.
- Facilities will use a comprehensive assessment tool to assess each patient's needs and determine the appropriate payment category. These assessments also will allow HCFA and the facilities to monitor and improve the quality of care.

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<sup>17</sup> PPS was also initially directed at other facilities other than acute inpatient rehabilitation hospitals, e.g. skilled nursing facilities and home health agencies.

- The proposal will adjust payments to rehabilitation facilities when a patient is transferred to another hospital or nursing home before completing the full course of care in order to ensure beneficiaries receive adequate care. (A similar policy is in place for acute care hospitals.)
- Payment rates for individual facilities will be adjusted to reflect geographic differences in wages, and for providing care to a disproportionate number of low-income patients. Rural providers will also receive a payment adjustment to account for their higher costs.
- Medicare will make additional payments for “outlier” cases involving beneficiaries with extraordinary care needs to ensure appropriate care for the sickest beneficiaries.

Originally, the law required the new system to establish payment rates so that estimated payments under the PPS would be 2 percent lower than the estimated payments that have been paid under the existing cost-based system. HCFA had stated that this provision would result in estimated savings for Medicare of \$1.5 billion over a period of seven years. However, the 2 percent reduction was rescinded in the Benefits Improvement and Protection Act of 2000 (PL 106-554, Sect. 305).<sup>18</sup> Now, the PPS will be budget neutral.<sup>19</sup>

After allowing additional time for the submission of written comments, HCFA has begun reviewing the public comments on its proposed rule to establish a PPS for inpatient rehabilitation hospitals and units.

Among the public comments HCFA received on the proposed rulemaking to establish the new PPS for inpatient rehabilitation hospitals and rehabilitation units were those from the American Medical Rehabilitation Providers Association (“AMRPA”), the national voluntary trade association which represents over 350 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and a number of outpatient rehabilitation facilities. Virtually all of AMPRA’s members are participating providers in the Medicare program. In its January 29, 2001 letter to Ms. Michael McMullan, Acting Administrator, Health Care Financing Administrator, commenting on the proposed new rules, AMPRA noted several areas of concern. From a policy perspective, AMPRA noted that the key areas that still needed to be addressed by HCFA were the content and burden of the proposed data assessment tool, the Minimum Data Set for Post Acute Care (“MDS-PAC”); the validity of the HCFA-adopted Hospital Specific Relative Value weights which predict cost per case; the impact of the outlier policy; co-morbidities; and several other details of the classification system. Another area that AMPRA asked HCFA to address during the comment period was the methodology used to determine the conversion factor which

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<sup>18</sup> American Medical Rehabilitation Providers Association, “Overview of the Proposed Rule for Inpatient Rehabilitation Facilities Prospective Payment System”, March 1, 2001, [www.amrpa.org/analysis-07.htm](http://www.amrpa.org/analysis-07.htm).

<sup>19</sup> Telephone contact with Jacqueline Gordon, HCFA Analyst, 4/01.

also impacts on the payment for each case. Additionally, there are several factors and wage indices used for different calculations that AMPRA members believe HCFA needs to clarify<sup>20</sup>.

With regard to how the rehabilitation PPS relates to Maryland's Health Services Cost Review Commission-set rates, Maryland acute care hospitals that have rehabilitation units are in the Medicare Waiver, and thus will be exempt from PPS. In addition, the rehabilitation units operated by Leivindale Hebrew Geriatric Center and Deaton Specialty Hospital are regulated by HSCRC under the Medicare waiver. The HealthSouth Chesapeake Rehabilitation Hospital, Kessler-Adventist Rehabilitation Hospital, Kennedy Krieger Institute, and Mt. Washington Pediatric Hospital are not in the waiver, and thus will be affected by PPS.

HCFA does not yet have a final implementation date for the PPS for inpatient rehabilitation hospitals. HCFA expects to have to educate and train providers about the new reimbursement system. The not-yet-announced implementation date will be included in the Final Rule, to be published in May 2001. The new rehabilitation payment system will be implemented with a two-year transition period. During this transition, HCFA has stated that rehabilitation facilities will receive blended payment rates that reflect facility-specific historical costs as well as the new prospective payment rates.<sup>21</sup>

## ***B. Chronic Hospitals***

### **1. Definition**

Chronic hospitals in Maryland are currently licensed as special hospital-chronic under COMAR 10.07.01.02B, if they offer a recognized program of specialized services to patients who need "...constant medical and nursing care by reason of chronic illness or infirmity; or have a chronic disability amenable to rehabilitation." (Health-General Article, §19-501 *et seq.*, Annotated Code of Maryland.)

Chronic hospital care can be provided in a variety of settings. This level of care could be provided in a freestanding facility devoted entirely to chronic hospital care, or can exist as a distinct unit in an acute general hospital or nursing home. While there are no freestanding chronic hospitals in Maryland (i.e. all chronic beds), seven facilities have a chronic hospital license, with a total of 547 licensed beds statewide. The seven facilities operate a total of 423 chronic hospital beds, and their chronic bed complements range in size from six to 180 beds. Five hospitals are private, and two are state-operated.

Chronic hospitals may be voluntarily accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") under hospital standards. Deemed status may be obtained for purposes of licensure and Medicare certification if the beds are JCAHO-accredited under hospital standards, or a facility may opt to be surveyed by the Maryland Department of Health and Mental Hygiene's Office of Health Care Quality ("OHCQ") as a hospital.

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<sup>20</sup>American Medical Rehabilitation Providers Association, "Overview of the Proposed Rule for Inpatient Rehabilitation Facilities Prospective Payment System", pages 12-13, [www.ampira.org/analysis/06.htm](http://www.ampira.org/analysis/06.htm).

<sup>21</sup>"Medicare News", November 2, 2000 found at [www.hcfa.gov/news/pr2000](http://www.hcfa.gov/news/pr2000), pages 1-2.

Based on the 1993 discussions by the Chronic Hospital-Technical Advisory Committee (“CH-TAC”) and its clinical workgroup, convened by the former Maryland Health Resources Planning Commission, the CH-TAC recommended a standard definition for a chronic hospital as follows: “an institution that provides continuous and intensive medical, nursing, and ancillary services to medically-complex patients whose severity of illness requires an intensity of service (that is, close professional monitoring and observation, and frequent intervention) either after an acute hospital phase of care or as a result of acute exacerbation of illness while resident in other settings (that is, home or nursing home).”<sup>22</sup>

The CH-TAC recommended that chronic hospitals be required in all cases to meet the same professional standards and regulations that apply to acute general hospitals. This would include requirements to maintain and operate facilities to provide diagnostic and treatment services under the supervision of physicians, who are members of an organized medical staff. Chronic hospitals would be required to provide, on site, the following: medical services, continuous R.N. nursing services, nutritional services, nutritional therapy, rehabilitation (physical, occupational, speech, and psychology therapies), and all ancillary treatment services.

Further, the CH-TAC described a chronic hospital patient as requiring a chronic hospital level of care and showing major sustained or major intermittent deficits in one or more body systems. Acute episodes or exacerbations of illness are common. Nursing interventions are complicated, and monitoring is frequent. The patient may not respond to a particular treatment, so changes in plans of care requiring timely medical and nursing intervention may occur often.

The CH-TAC proposed that the following generic clinical criteria should be used to describe those who require a chronic hospital level of care. Patients must meet all three criteria:

1. Requires frequent physician intervention (on average, three visits per patient per week).
2. Requires continuous intensive professional nursing services and intervention from a registered nurse. Examples include, but are not limited to, frequent deep tracheal suctioning (more frequently than six times daily), total parenteral nutrition, serious wound (such as, multiple stage III or stage IV decubiti) care, and management of acute medical exacerbations appropriate to the resources of the chronic hospital.
3. Has a medical condition that is sufficiently complex to require continuous monitoring, and requires an intensity of resources that is not available in alternative non-acute hospital settings<sup>23</sup>.

In summary, the MHRPC’s Technical Advisory Committee believed that this level of care reflects a patient who, while not in an acute phase of an illness, requires a *hospital* level of care that provides the necessary intensive staffing (by a physician and registered nurses) for

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<sup>22</sup>Maryland Health Resources Planning Commission, *An Analysis of Chronic Hospitals in Maryland: A Report of the Chronic Hospital Technical Advisory Committee, December 1993*, p. 23

<sup>23</sup> Ibid.

continuous monitoring of the patient's medical needs. The patient would require the medically necessary support and ancillary diagnostic and treatment services not typically available in alternative non-acute hospital settings.<sup>24</sup>

## **2. Supply and Distribution of Chronic Hospitals in Maryland**

While there are no hospitals totally comprised of special hospital-chronic disease beds in Maryland, seven (7) facilities are licensed to provide special hospital chronic care by Maryland's Office of Health Care Quality, with a statewide total of 547 chronic hospital beds. Additionally, these seven hospitals are also licensed for a total of 477 comprehensive care/sub-acute beds, (See Table 3) Subacute care is also provided in other skilled nursing facilities and extended care facilities statewide.

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<sup>24</sup> Ibid, p. 24.

**Figure 2**  
**Inventory of Licensed Beds at Facilities with Special Hospital -Chronic and Other**  
**Types of Beds**

<b>Type of Licensed Beds</b>					
<b>Facility</b>	<b>Special Hospital-Chronic</b>	<b>Rehabilitation</b>	<b>Comprehensive Care (Sub-Acute)</b>	<b>Communicable Disease Beds</b>	<b>Acute</b>
<b>Baltimore City</b>					
Deaton	180 <sup>25</sup>				
Johns Hopkins	62	4	22	22	
Bayview <sup>26</sup>					
James Lawrence	6	98	30		7
Kernan Hospital <sup>27</sup>					
Levindale	80 <sup>28</sup>	20	192		
<b>Prince George's County</b>					
Spellman	30		80		
<b>Washington County</b>					
Western Maryland Hospital Center <sup>29</sup>	123		63		
<b>Wicomico County</b>					
Deer's Head <sup>30</sup>	66		90		
<b>Total State</b>	<b>547</b>	<b>122</b>	<b>477</b>		<b>7</b>

<sup>25</sup> Deaton's chronic bed complement is broken down as follows: 20 Psych Rehab beds, 38 ventilator Dependent beds, and 122 Chronic beds for a total of 180 special hospital –chronic. Source: Maryland Health Services Cost Review Commission.

<sup>26</sup> Johns Hopkins 22 Comprehensive Care beds are dually licensed as Communicable Disease Beds, but are temporarily off-line.

<sup>27</sup> In an October 31, 1996 letter, the Maryland Health Resources Planning Commission ("MHRPC") approved the temporary delicensure of 50 chronic hospital beds in conjunction with the consolidation of the James Lawrence Kernan Hospital and Montebello State Hospital. By letter dated May 22, 1997, the MHRPC approved the re-licensure of six chronic hospital beds.

<sup>28</sup> Levindale has a total of 292 beds. Of the 80 beds licensed as Special Hospital-Chronic, 20 beds are designated as Gero-Psych. Of the 192 comprehensive care beds, 20 are designated as SNF.

<sup>29</sup> Western Maryland Hospital Center is budgeted for a total of 115 beds. WMC is budgeted for 52 chronic hospital beds and for those it has an 83% occupancy. It is licensed and budgeted for 63 comprehensive care beds and has a 95% occupancy rate as of 4/13/01. It is licensed for 123 chronic care beds and based on that licensed amount would have an occupancy rate of 34%.

<sup>30</sup> While Deer's Head Center is licensed for 66 chronic hospital beds, it is only budgeted for 13 chronic hospital beds. Its occupancy for the budgeted beds was 64% as of February 2001. The occupancy for the licensed capacity of 66 chronic beds was 11% for the same time period. Regarding its comprehensive care beds, DHC is budgeted for 72 comprehensive care beds with an occupancy of 96% as of February 2001. Considering that it is licensed for 90 comprehensive care beds, its occupancy would be 77% for the same time period. Source: Telephone contact 4/12/01 with Ruth Potvin, Management Associate, Director's Office.

### **3. Trends in the Utilization of Chronic Hospitals in Maryland**

#### **Characteristics of Chronic Hospital Patients**

Patient- and facility-specific profiles for Maryland's chronic hospitals (including the New Children's Hospital which closed in May 1999) for the years 1996-1999, the latest date for which data are available, were developed by Commission staff from the Maryland Sub-acute Care Surveys.<sup>31</sup>

#### **Demographic Profile: Race and Gender**

From January 1, 1999 to December 31, 1999, there were 1,788 patients discharged from chronic hospitals statewide. About 54 percent were White and 43 percent were African-Americans; 52 percent were female.

#### **Length of Stay: Mean and Median**

The statewide mean length of stay ("LOS") for patients discharged from chronic hospitals during 1999 was about 51 days; the median LOS was 21 days. This difference between the mean and median LOS is a result of patient outliers with very long lengths of stay (greater than 365 days). The 1999 data show marked differences among the chronic hospitals (excluding the now-closed The New Children's Hospital) in mean lengths of stay, from a low of 21 days at Johns Hopkins Bayview to a high of 90 days at Western Maryland Hospital Center.

The variation in LOS may be related, in part, to the types of patients served and the discharge practices of each facility. The Western Maryland Center's relatively high mean LOS of 90 days and median LOS of 49.5 days may result from its treating ventilator-dependent patients, who generally have longer lengths of stay. The WMC has a maximum of 20 beds to treat ventilator-dependent patients. The other state-operated chronic hospital, Deer's Head Center, does not serve ventilator-dependent patients. In addition, WMC treats patients diagnosed with tuberculosis, who will also have extended lengths of stay.<sup>32</sup>

#### **Patient Origin**

Most of the chronic hospital patients discharged during 1999, were from Baltimore City (44.85 percent), Baltimore County (20.41 percent), and Washington County (5.65 percent).

The patient origin distribution in Maryland's chronic hospitals appears to reflect the number of chronic hospital beds located within, or adjacent to, these jurisdictions. However, the patient origin distribution does not reflect the total state population distribution. Both Prince George's and Montgomery Counties have a large share of Maryland's total population and population aged 65 and older; however, there are relatively few reported chronic hospital patients from these two jurisdictions: 5.20 percent and 1.34 percent, respectively. For calendar year

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<sup>31</sup> Data for the James Lawrence Kernan Hospital's 6 chronic hospital beds are not available.

<sup>32</sup> Telephone contact April 27, 2001 with Kay Pryor, Secretary to Barbara Galloway, Director of Clinical Services, Western Maryland Center.

1999, about 2.4 percent of the patients at Spellman, in Prince George's County, were Montgomery County residents, and 65.06 percent were residents of Prince George's County.

### **Living Situation Before Admission**

With regard to an individual's household composition before admission to a health care facility, about thirty-five percent of the patients discharged from chronic hospitals in 1999 were living with relatives--a spouse (22.04 percent), children (6.26 percent), or other relatives (7.05 percent). Of the remaining 64.65 percent: 20.47 percent lived alone, 7.61 percent lived with unrelated persons in an institutional setting, 19.07 percent were in some other living situation, or 17.28 percent were in an unknown living situation.

### **Source of Admission**

Statewide, the vast majority of chronic hospital patients in calendar year 1999 were admitted directly from acute care hospitals (medical/surgical units) (91.55 percent); the other major sources of admission were comprehensive care facilities (2.57 percent), rehabilitation hospitals (2.18 percent), other chronic hospitals (2.07 percent), and private residence (1.12 percent).

There are differences in the predominant admission sources among the chronic hospitals. For example, patients admitted directly from acute care hospitals represented all of the admissions to the Gladys Spellman Specialty Hospital and Nursing Center, but only 85.96 percent of Deer's Health Center's chronic hospital patients. Other major sources of admission at Deer's Head Center included private residence (5.26 percent), comprehensive care facility (1.75 percent), other chronic hospitals (1.75 percent), ICF-mentally retarded facility (1.75 percent), and other unnamed sources of admission (3.51 percent).

### **Major Principal Diagnosis on Admission**

Many of the chronic hospital patients discharged during 1999 were admitted with a principal diagnosis of other lung diseases (27.29 percent), chronic ulcer of skin (9.62 percent), cerebrovascular accident (3.97 percent), other brain injury (3.80 percent), and chronic renal failure (3.36 percent). While this represents a statewide distribution of the principal diagnosis on admission, it is important to highlight some facility-specific differences.

For example, over 65 percent of Spellman's patients presented with a diagnosis of other lung diseases and over 53 percent of Levindale's patients presented with the same diagnosis. No other chronic hospital had this high a percent for this diagnosis. Western Maryland Center and Deer's Head Center reported patients with a principal diagnosis of chronic renal failure accounted for 13.25 percent and 8.77 percent of hospital admissions respectively in 1999. No other chronic hospital reported as high a percentage.

These variations may be due, in part, to the types of specialty units developed by some facilities, (such as the renal dialysis units at Western Maryland Center and Deer's Head Center) and operated under their chronic hospital licenses.



## Patient Discharge Disposition

Over one third of the 1,788 patients discharged from the chronic hospitals in 1999 were discharged to an acute hospital (medical/surgical unit) (37.64 percent). Others were discharged to private residences (26.12 percent), or comprehensive care facilities (14.04 percent); rehabilitation hospital (2.29 percent); and a category termed “not applicable”(14.71 percent).

Regarding facility specific differences, more than fifty percent of the patients at Johns Hopkins Bayview were discharged to private residences, as compared to Spellman’s patients, only 1.2 percent of whom were discharged to private residences. The typical Spellman patient was primarily discharged to acute care hospitals (50.60 percent), comprehensive care facilities (19.28 percent), and to the category termed “not applicable” (28.92 percent).

## Principal Payment Source on Admission

The major payment sources were Medicare and Medicaid (61.80 percent and 22.65 percent, respectively). The mix of other payment sources on admission include: private insurance (11.30 percent), health maintenance organization (2.52 percent), other state Medicaid (0.45 percent), and self-pay (0.22 percent).

## Private Chronic Hospitals

The Health Services Cost Review Commission (“HSCRC”) sets rates for the five private chronic hospitals. The HSCRC has established these rates by conducting a “full rate review” of the chronic hospital’s rates. The full rate review process involves comparing the departmental expenses of a chronic hospital to the average expenses of a peer group of similar hospitals to determine if the hospital’s budgeted expenses are reasonable. Adjustments are then made in this methodology to reflect the chronic hospital’s specific debt service, level of uncompensated care and mix of payers. The resulting expenses are then adjusted for inflation and divided by the expected volume (patient days for the chronic center) to establish the rate.

**Table 4**  
**Comparison of Maryland Private Chronic Hospital Rates**

<b>Facility</b>	<b>No. of Licensed Chronic Hospital Beds</b>	<b>Daily Rate (Room, Board, Routine Nursing)</b>	<b>Effective Date</b>
Deaton	180	\$488.32	07/01/00
Johns Hopkins	62	\$537.47	07/01/00
Kernan	6	\$469.22	02/01/00
Levindale	80	\$477.97 <sup>33</sup>	03/01/00
Spellman	30	\$419.07	07/01/00

Source: Health Services Cost Review Commission

<sup>33</sup> HSCRC has allowed Deaton and Levindale to establish two separate unit rates for their chronic beds, one rate for Chronic Care and another rate for Respiratory Dependent Care. For comparative purposes, the MHCC Staff has combined the two rates to get the overall approved rate for the chronic beds.

The HSCRC-approved rates for Deaton, Johns Hopkins, Kernan, Levindale and Spellman fall within the range of \$419 to \$537 per day. These rates vary for a number of reasons: one, the wage rates that the hospitals pay their employees is different for all hospitals; two, the hospitals all have different amounts of debt service in rates, depending upon the age of their facilities and the financing cost of their debt; three, the amount of uncompensated care varies depending upon the patient population that the facility services; and four, the payer mix that each hospital serves varies. In addition to these reasons, the daily rate for Spellman is less than the other four facilities, because it is located in a building separate from the main acute hospital building at Prince George's Hospital Center.

The chronic rates at the State facilities, Deer's Head Center and Western Maryland Center, were supplied to Commission staff by the State Office of Program Cost and Analysis within the Department of Health and Mental Hygiene. The \$586 rate at Western Maryland Center and the \$1,441 rate at Deer's Head Center, are the highest chronic rates in the State, and were calculated by dividing the total costs of the hospitals by the total patient days for fiscal year 2000.

Since the HSCRC sets rates for chronic care at certain hospitals, and the State operates and finances the patient care at two chronic hospitals, it is difficult to determine total costs related to all chronic hospital patients. The HSCRC has exempted Levindale, Deaton, and Spellman from reporting medical records abstract information on chronic patients, so there is no uniform method of obtaining information on charge per admission for chronic patients at those facilities.

Both Medicare and Medicaid reimburse hospitals under the HSCRC's jurisdiction at 94 percent of the facility's HSCRC-approved rates. Medicare and Medicaid receive this six percent discount because of the terms of Maryland's waiver from the Medicare Hospital PPS system. Private third party payers may be eligible for a four percent SAAC (substantial, available, and affordable coverage) discount that requires, among other things, participation in open enrollment. All SAAC discounts to third party payers must be specifically approved by the HSCRC. Private third party payers may also be eligible for a two percent discount if they provide working capital deposits to hospitals or a 1% discount if they pay bills within a certain time period.

The State-run chronic hospitals are paid by Medicare under the current national cost-based reimbursement system. Both hospitals submit cost reports to Medicare every year, and Medicare pays the hospitals a percentage of that cost, based on its principles. The Maryland Medicaid Program follows Medicare's reimbursement principles, and also requires that both hospitals submit a similar report. In the aggregate, Medicare and Medicaid account for 35% and 37%, respectively, of the total admissions to the two State hospitals.

## State-Operated Chronic Hospitals

**Table 5**  
**Comparison of State-Operated Maryland Chronic Hospitals**

<b>Facility</b>	<b>No. of Licensed Chronic Hospital Beds</b>	<b>Daily Rate</b>
Deer's Head <sup>34</sup>	66	\$1,441.00
Western Maryland Center	123	\$586.00

The Community and Public Health Administration oversees the State's two chronic care hospitals, Western Maryland Center and Deer's Head Center, and the directors of these two facilities report directly to the Director of the Community and Public Health Administration. Both WMC and DHC operate more or less independently from the other divisions within that administration. Among other medical services, both centers provide: chronic care and treatment to patients requiring a hospital-level rehabilitation program, that is the level of physician and nursing management greater than that available at a nursing home; long-term nursing home care for patients no longer in need of hospital-level care but whose needs require services that are beyond those typically offered in the private sector in nursing homes; and inpatient and outpatient renal dialysis services.

In an analysis of the 2002 Operating Budget for these two chronic hospitals, the budget analyst of the Department of Legislative Services noted in her assessment for the legislature that the WMC and DHC both face financial difficulties which will limit the ability of these hospitals to increase their patient population. Given that the hospitals remain in a cycle of deficit spending, the Department of Legislative Services recommended that the hospitals hold some new positions vacant to cover their higher operating expenses.

Since the 1990s, both DHC and WMC have been running budget deficits. The chronic hospitals are caught between competing pressures—pressure to increase occupancy rates and pressure to keep within budgetary limits. However, the hospitals have been unable to live up to either demand. With escalating costs for staffing, pharmaceuticals, and utilities, among others, the hospitals cannot even maintain existing operations without running deficits. In fiscal 2000, the hospitals overspent their budgets by \$900,000 for non-dialysis services, but they were still slightly under their targeted census. DHMH had to cover the loss with savings from other programs. The hope was that the hospitals could finally obtain an increase in the census in fiscal 2001, with additional funds to support new positions and operating costs. However, this hope has not been realized, and the hospitals have continued the cycle of deficit spending; they are on a pace to overspend their FY 2001 budgets for non-dialysis services by close to \$1 million.

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<sup>34</sup> As noted above, rates for the two State-operated chronic hospitals are based on consideration of total costs divided by inpatient days. For Deer's Head Center, FY 2001 inpatient days totaled 4,380, inpatient days for FY 2000 totaled 4,392. For Western Maryland Center, inpatient days totaled 18,615 in FY 2001 and 18,300 in FY 2000. In the case of DHC, costs are spread over fewer people, and thus the daily rate is higher than for WMC. Source: Telephone contact April 19, 2001 with Allen Wood, Chief, Fee Payment Section, Division of Costs and Analysis, Office of Budget Management, DHMH.

The DLS analyst reported to the General Assembly during the 2001 session that the State-operated chronic hospitals are under pressure to increase occupancy rates because of changes in the health care system. Not only are nursing homes and other hospitals reluctant to keep patients with high acuity levels, but also reimbursement from public and private insurance often does not cover the expenses of sicker patients. The demand for beds at WMC and DHC is evidenced by waiting lists of 13 and 12 patients, respectively.

While both hospitals have a history of deficit spending, each has a unique set of financial problems. WMC's deficit is driven by the liberalization of a sick leave policy, which has increased overtime costs, and rising supply costs, particularly related to pharmaceuticals, which are difficult to control. DHC has experienced the same problem with pharmaceutical costs, especially with patients with tuberculosis and/or AIDS<sup>35</sup>. Skyrocketing utility prices have also contributed to DHC's deficit.

The hospitals have planned to increase their average daily census to 208 for both in fiscal 2001, which is 25 over the current average daily census. (See Table 6 below) To achieve this goal, they requested, and received, legislative approval for just under \$2 million for new personnel and operating expenses, and another \$2 million to keep up with salary and benefit increases for existing personnel. This requested amount may not be sufficient to cover the proposed increase in the census, given the historic pattern of deficit spending for the existing population.

**Table 6**  
**Targeted and Actual Patient Census: Western Maryland Center**  
**And Deer's Head Center, Fiscal Years 2000 - 2002**

<b>Facility</b>	<b>Fiscal 2000</b>	<b>Fiscal 2001</b>	<b>Fiscal 2002</b>
<b><u>Western Maryland Center</u></b>			
Targeted Census	110	113	118
Actual Census	112	105	n/a
<b><u>Deer's Head Center</u></b>			
Targeted Census	80	87	90
Actual Census	76	78	n/a
<b><u>Total</u></b>			
Targeted Census	190	200	208
Actual Census	188	183	n/a

Even though there has been an increase in the chronic hospitals' allowance for FY 2002, it does not include about \$400,000 that the hospitals requested for supplies and equipment. The Department of Budget and Management cut these funds, directing the hospitals to slow the growth in the census. The DLS budget analyst noted that since the hospitals will need fewer

<sup>35</sup> Deer's Head Center has between 3-6 tuberculosis quarantine patients who usually have AIDS as well. These patients require costly pharmaceuticals in their treatment. Additionally, while DHC does not treat patients who are ventilator dependent, it has two Traumatic Brain Injury patients who require 24-hour nursing care and one of these patients has the need for two nursing staff at all times. ( Source: Telephone contact with Legislative Budget Analyst Robyn Elliott, April 18, 2001.)

positions to accommodate a lower census, they can move funding from the new positions to supplies to make up the difference.

Faced with these significant financial issues, the State-operated chronic hospitals have developed focused managing for results (“MFR”) plans, under the budget department’s Managing for Results initiative, as outlined in Table 7. WMC’s plan focuses on moving patients out of the hospital or into lower levels of care, while DHC’s plan emphasizes quality of care measures. The DLS budget analyst has recommended that DHC include measures related to de-institutionalization, given the Supreme Court’s *Olmstead vs. L.C.* decision. (see the following section’s discussion of this important case), and WMC should institute quality measures, such as the focusing on lowering the percentage of residents with pressure ulcers. The Office of Health Care Quality, which is responsible for the inspections of health care facilities, uses similar measures in its MFR.

#### **4. Community-Based Alternatives to Chronic Hospital Care**

In addition to the challenges of financial uncertainties and quality concerns facing chronic hospitals today, these facilities also have to confront the challenges presented by the July 1999 United States Supreme Court decision, *Olmstead v. L.C.*<sup>36</sup>

The Court’s decision in that case clearly puts federal, state, and local governments to the test to develop more de-institutionalization opportunities for individuals with disabilities, through more accessible systems of cost-effective, community-based services. The *Olmstead* decision further interpreted Title II of the Americans with Disabilities Act (“ADA”) and its implementing regulation, requiring states to administer their services, programs, and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”<sup>37</sup> Communications from the U.S. Department of Health and Human Services (“HHS”) to state governments leave no doubt that the federal government, and particularly HCFA, is interpreting *Olmstead v. L.C.* as covering any individual with a disability who lives in an institutional setting<sup>38</sup>.

In response to this federal-level interpretation, the State of Maryland has expanded its existing planning and development of community-based services and is implementing new initiatives under Medicaid. A frequently pursued mechanism for these initiatives is obtaining a “waiver,” an exception granted by HCFA to certain federal regulations -- in this case, those governing Medicaid. Such waivers are authorized when it becomes cost effective to do so, but only if the quality of medical care is maintained [§1915 (c)]. Typically, a waiver will seek to help people who otherwise would require a hospital or a facility providing skilled nursing or

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<sup>36</sup> All long term care facilities, including inpatient rehabilitation facilities, will face these challenges following the *Olmstead* decision. However, in the case of inpatient rehabilitation hospitals, patients are treated up to a level of recovery at which point, they reach a plateau and after which they would be discharged to either home or another level of care.

<sup>37</sup> Health Care Financing Administration website: [www.hcfa.gov/medicaid/olmstead/olmshome.htm](http://www.hcfa.gov/medicaid/olmstead/olmshome.htm), August 29, 2000

<sup>38</sup> The Supreme Court cautioned, however, that “nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings.” *HFAM Networks*, July/August 2000, p. 8.

intermediate care.<sup>39</sup> This waiver allows the State to create a plan to find the least restrictive environment for disabled individuals whether they are in institutional settings or are at risk for entering one.

One such initiative, already discussed at length in *An Analysis and Evaluation of the CON Program, Phase 1*, is the Medicaid Home and Community-Based Services Waiver for Older Adults. This waiver provides a package of 16 home and community-based services for qualified older adults (aged 50 and older) who need (and qualify for) nursing home level of care, but live at home or in a licensed assisted living facility.<sup>40</sup>

Another such initiative is the Medicaid Attendant Care Waiver. The Attendant Care Waiver, with its current working title “Living at Home: Maryland Community Choices,” became effective April 1, 2001. Its goal is to secure a more consumer-responsive Medical Assistance Personal Care Program<sup>41</sup>, and to create a personal assistance system for Medical Assistance recipients that is responsive, flexible, offers quality services, and develops partnerships. The Attendant Care Waiver is currently capped at 400 participants, aged 21-59, with 150 to be participating in the first year, 300 in the second year, and 400 by the end of the third year.

The philosophical foundation on which this particular waiver rests has two supporting components. The first is one of self-determination: the Medical Assistance recipient has the right and responsibility to make his or her own decisions; to decide where he or she is going to live; to determine the utilization of resources under this waiver; and to participate fully and equally in the community. Secondly, this waiver is consumer-directed: i.e., the individual will make decisions regarding the type and the amount of assistance or services he or she receives.

The services available in the “Living at Home: Maryland Community Choices” waiver to those 21-59 year olds who are residents of a nursing home, or are at risk for entry into a nursing home – and this would include those in rehabilitation hospitals or chronic hospital settings -- include the following:

- ? Attendant Care Services
- ? Case Management
- ? Assistive Technology
- ? Consumer Training
- ? Durable Medical Equipment/Supplies
- ? Environmental Accessibility/Adaptations
- ? Family Training
- ? Skilled Nursing Supervision of Attendants
- ? Occupational Therapy
- ? Personal Emergency Response Systems

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<sup>39</sup> [www.mdarchives.state.md.us/msa/mdmanual](http://www.mdarchives.state.md.us/msa/mdmanual)

<sup>40</sup> Maryland Health Care Commission, *An Analysis and Evaluation of the CON Program, Phase 1, Nursing Homes, January 1, 2001, pages 160–164.*

<sup>41</sup> The existing Medical Assistance Personal Care Program reimburses for personal care services provided to chronically ill or disabled Medicaid recipients who are under the care of a physician and require assistance at home with activities of daily living. The objectives of the program are to prevent patient deterioration, to delay institutionalization, and to prevent inappropriate institutionalization.

- ? Speech/Language Services
- ? Transportation

The expansion of this and other waivers, if they are seen to be successful and continue to attract support and funding from policymakers at the state and local levels of government, could have a significant impact on the utilization of rehabilitation and chronic hospitals, and therefore future bed need.

In its *Olmstead* decision, the Supreme Court affirmed that the unjustified segregation and institutionalization of people with disabilities constitutes unlawful discrimination in violation of the American's with Disabilities Act. The federal Department of Health and Human Services ("DHHS") is providing technical assistance to promote effective implementation of its longstanding policy of facilitating care and service provision in the most integrated setting. Specifically, the Office for Civil Rights ("OCR") is working with HCFA to provide technical assistance regarding individual state's compliance with the ADA. Also, federal financial participation (federal funding) is available at the administrative rate to design and administer plans to serve individuals with disabilities in the most integrated setting, subject to the normal condition that the changes must be necessary for the proper and efficient administration of a state's Medicaid program.

Moreover, the federal DHHS has stated that it is reviewing its own policies, programs, statutes, and regulations to identify ways to enhance and improve the availability of community-based services. DHHS has also stated that it recognizes that key programs, such as Medicaid, may sometimes present difficulties for people with disabilities to have access to quality care in the community. Further, DHHS has stated that it is developing and will implement its own comprehensive plan to eliminate these barriers. Recognizing that housing is a critical need, DHHS has stated that it is working with the Department of Housing and Urban Development ("HUD") to improve affordable, accessible housing opportunities for people with disabilities. DHHS has stated that it is committed to working with states to increase community-based alternatives to institutional care.<sup>42</sup>

Under the Attendant Care Waiver in Maryland, it is envisioned that the participant will be able to use either one of two attendant care service models: agency-employed or consumer-employed, to secure services. To be eligible for the waiver, the participant's cost of care should be equal to or less than the participant's cost of care in the institutional setting. Additionally, the waiver will have available State funding for services including a security deposit for a waiver participant's apartment, the purchase of household items, transportation, respite, mental health services, and heavy chore services. Non-waiver services not included in computing the waiver cost of care are those for administration, case management, and the fiscal intermediary functions.<sup>43</sup>

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<sup>42</sup> State Medicaid Director Letter – "Olmstead Update No. 2, Questions and Answers," July 25, 2000  
[www.hcfa.gov/medicaid/smd72500](http://www.hcfa.gov/medicaid/smd72500)

<sup>43</sup> Administration of the waiver will be under the auspices of the Office of Personal Assistance Services at the Department of Human Resources, with case management performed regionally by local health departments, and the fiscal intermediary functions will be performed on a regional basis. Case management functions will include assessment, planning, and enrollment coordination; ongoing case management such as service coordination and

In addition to Maryland's response to the *Olmstead* decision discussed above, the State has sought and been granted other waivers from HCFA, since waivers are seen as an effective health policy and planning tool. Not only do they allow states to set aside certain federal requirements, they also allow states to expand covered services to include services not traditionally covered by Medicaid, and to establish specific financial and technical eligibility criteria for each specific waiver. The "fail-safe" that qualifies all waivers and the participation of individuals in these waivers is a cost-effectiveness principle: if the cost of serving a prospective enrollee in the community would be higher than caring for that individual in an institutional setting, then that person may not be a part of that waiver program.

Another waiver with relevance to the rehabilitation or chronic level of inpatient care, proposed by Maryland Medicaid's Office of Health Services and the Mental Hygiene Administration ("MHA") and awaiting approval by HCFA, is the Waiver for Adults with Traumatic Brain Injury ("TBI"). If approved, it is anticipated that this waiver will serve those individuals in Maryland 22 – 64 years of age who have been diagnosed with traumatic brain injuries which occurred at age 22 or older. The individuals must be assessed as meeting a chronic/specialty hospital level of care or a nursing facility level of care. The waiver program submitted to HCFA would cover case management, family training, respite care, and modifications to a person's living environment. The Waiver for Adults with Traumatic Brain Injury would be administered for the State by MHA.<sup>44</sup> Medicaid reports that due to federal policy changes following the *Olmstead* decision, HCFA is re-examining Maryland's original waiver proposal for this population.<sup>45</sup>

## **5. Reimbursement Issues**

Chronic hospitals under the jurisdiction of the are currently exempt from the federal Prospective Payment System, while the two State-operated chronic hospitals, Western Maryland Center and Deer's Head Center, are reimbursed based on allowable costs. According to Section 42 Code of Federal Regulations, hospitals under cost-based reimbursement must have a Medicare provider agreement to participate as a hospital, and must maintain a minimum 25-day average length of stay. Commission Staff has learned during the preparation of the Working Paper that HCFA is preparing a Notice of Proposed Rulemaking for a Prospective Payment System for chronic hospital service, or what the federal agency terms "long term hospital" service. However, no date has been set for the release of this notice of proposed rules.<sup>46</sup>

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monitoring; and re-assessments. Fiscal intermediary functions will include payment processing, fiscal accounting, and reporting.

<sup>44</sup> In June 1999 the federal Health Resources and Services Administration ("HRSA") approved MHA's proposal for a three-year TBI implementation grant, which focuses on statewide training and outreach for individuals with brain injuries, their families, and caregivers. This implementation grant is an educational outreach grant focused on the following: the support of an individual after he or she has been diagnosed with TBI, on teaching professionals what resources are available for TBI patients, on helping police officers recognize signs of TBI. Additionally, the grant will seek to help patients better manage their illness. The grant seeks to develop a statewide action plan. However, it should be noted that this grant does not provide any services.

<sup>45</sup> Status Report on Traumatic Brain Injury ("TBI") Model Waiver from Division of Waiver Programs, Office of Health Services, Medical Care Programs, April 6, 2001.

<sup>46</sup> Commission Staff telephone contact with HCFA Analyst Jacqueline Gordon 3/29/01.



The issue of reimbursement for chronic hospital patients is particularly pressing for those patients who have diagnoses related to emphysema, heart disease, and spinal cord injury. As noted above, for 1999 the principal diagnosis on admission for 27.29 percent of patients admitted to Maryland's chronic hospitals was other lung diseases. These patients may be on ventilators, and may never again breathe independently, yet many will live for months or years after becoming ventilator-dependent. As the population ages and advances are made in medical technology, the number of patients in the United States who are ventilator-dependent has been rising, from 6,000 in the mid-1980's to at least 12,000 and perhaps as many as 20,000 or more today. The number of facilities caring for these patients nationwide has also grown, from about 100 in 1990 to 240 today.

Ventilator-dependent care is expensive: usually tens of thousands of dollars per patient per year. Some patients eventually recover to the point that they do not need ventilators, but the weaning process is tricky, and -- although there are some standard tests to test when a patient is ready to be weaned -- no perfectly predictive criteria exist. Mechanical ventilation itself can cause further problems with lung complications, including pneumonia and adult respiratory distress syndrome.

The growth in the number of facilities treating ventilator-dependent patients can be traced to 1983, when Medicare began to reimburse hospitals based on each patient's diagnosis, rather than actual treatment costs. Under this payment system, it did not make financial sense for acute care hospitals to keep ventilator-dependent patients in intensive care units for more than about three weeks; however, since "long-term care hospitals" -- Maryland's chronic care hospitals -- were exempt from this provision, many of them started providing higher levels of care. There is significant concern among the hospitals providing this care that, with HCFA planning to convert long-term/chronic hospitals to the diagnosis-based payment system, stringent cuts in reimbursement may particularly compromise ventilator-dependent patients in chronic hospitals.

Tom Scully, Executive Director of the Federation of American Hospitals, a national trade association that represents about 6,000 hospitals and long-term care facilities, has noted the need to find a payment system that would keep the long-term/chronic hospitals viable and operating -- even while some health experts question whether chronic ventilation is the best treatment for many of the people who receive it. "These individuals endure months of intensive medical management and personal discomfort," the researchers, led by Dr. Shannon Carson, wrote in *The American Journal of Respiratory and Critical Care Medicine*. However, others say the prognosis is not so dismal. Dr. David Scheinhorn, Director of Research at Barlow Respiratory Hospital in Los Angeles, said recent research showed that 38 percent of 1,100 patients studied were alive after a year. The outcomes are poor, he said, but not as bad as some might think. "Someone needs to take care of these people," he said.<sup>47</sup>

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<sup>47</sup> Sandeep Jauhar, "As Technology Improves, More People Breathe With Machines," *The New York Times*, April 24, 2001, [www.nytimes.com/2001/04/24/health/24VENT](http://www.nytimes.com/2001/04/24/health/24VENT)

### **III. GOVERNMENT OVERSIGHT OF REHABILITATION AND CHRONIC HOSPITAL SERVICES**

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Government oversight of both inpatient rehabilitation hospitals and chronic hospital services -- including facilities, staff, and program operation -- is the responsibility of both federal and State agencies. Although this report focuses on the oversight responsibilities of the Maryland Health Care Commission, it is also important to consider how rehabilitation and chronic hospital services are regulated by other government agencies. Listed below is a summary of the primary federal and State agencies that play a role in the regulation and oversight of the provision of rehabilitation and chronic hospital services in Maryland.

#### **Federal Level**

##### **? *Health Care Financing Administration***

The Health Care Financing Administration (“HCFA”) within the United States Department of Health and Human Services (“DHHS”) is the federal agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program (“SCHIP”). HCFA provides health insurance for over 74 million Americans through Medicare, Medicaid, and SCHIP. In addition to providing health insurance, HCFA also performs a number of quality-focused activities, including regulation of laboratory testing, surveys and certification of health care facilities (including inpatient rehabilitation facilities and chronic hospitals), and provides to beneficiaries, providers, researchers, and State surveyors information about these and other activities related to quality of care improvement.

##### **? *Office of the Inspector General***

The Office of the Inspector General (“OIG”) within the federal DHHS is composed of the Office of Audit Services, Office of Investigations, the Office of Evaluation and Inspections, and the Counsel to the Office of Inspector General. The OIG works with HCFA to develop and implement recommendations to correct systemic vulnerabilities detected during OIG/HHS investigations of care provided in health care facilities such as rehabilitation and chronic hospitals. The OIG believes that an effective compliance program provides a mechanism that brings the public and the private sectors together to reach mutual goals of reducing fraud and abuse, improving the quality of health care services, and reducing the overall cost of health care.<sup>48</sup>

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<sup>48</sup> [www.hhs.gov/progotg/oig](http://www.hhs.gov/progotg/oig)

## **State Level**

### **? *Maryland Department of Health and Mental Hygiene***

The Maryland Department of Health and Mental Hygiene (“DHMH”) develops and oversees public health programs with the goal of protecting the health of Maryland residents. A highly complex organization with a broad scope of responsibility, DHMH is comprised of over 30 program administrations, 24 local health departments, over 20 residential facilities, and more than 20 health professional boards and commissions. The Maryland Medical Care Programs (the Medical Assistance Program [“Medicaid”] and the Pharmacy Assistance Program) are also located organizationally within DHMH. Responsibility for overseeing the running of two State chronic hospitals, Western Maryland Center and Deer’s Head Center, rests with the DHMH’s Community and Public Health Administration, discussed further below.

### **? **Office of Health Care Quality****

The Office of Health Care Quality (“OHCQ”), is the administration within DHMH mandated by State and federal law to determine compliance with the quality of care and life safety standards for a variety of health care services and related programs, including rehabilitation hospital and chronic hospital services.<sup>49</sup> The agency is responsible for licensing, certifying, or otherwise approving providers who provide health care and services. It also investigates quality of care complaints from members of the public. The OHCQ monitors quality of care and compliance with both State and federal regulations in 8,000 health-care facilities and health related services and programs. In order to regulate these institutions and programs, the OHCQ conducts more than 10,000 inspections yearly statewide.

Currently, rehabilitation hospital and chronic hospital providers must renew their licenses every three years. The renewal fee is \$300.00. OHCQ will survey a rehabilitation or chronic hospital when it receives a complaint, or HCFA requests that OHCQ validate one of HCFA’s accreditation surveys. HCFA is mandated to survey 5% of hospitals nationwide. HCFA usually tries to obtain a cross section of all types of hospitals: acute, special hospitals, and rehabilitation hospitals.

Regarding data collection, the Office of Health Care Quality is currently working to update its database for complaints and surveys for rehabilitation and chronic hospitals, as well as the other services it monitors.

### **? **Maryland Medical Care Programs (Maryland Medicaid and the Maryland Pharmacy Assistance Program)****

Under the Maryland Medical Assistance Program (“Medicaid”), rehabilitation hospital and chronic hospital services are reimbursed for medically and financially eligible Medicaid recipients. A recipient must be certified by the Program’s Utilization Control Agent, the Delmarva Foundation for Medical Care, as requiring health related services above the level of

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<sup>49</sup> Subtitle 12 and Subtitle 5 under Health-General Article 19 further articulates the licensure requirements for rehabilitation and chronic hospitals.

room and board, which can be provided only through institutional services. With regard to rehabilitation hospital services, in fiscal year 2000, (the most recent date for which data are available) Medicaid reimbursed 11 of the State's 15 licensed rehabilitation hospitals for services to its recipients. During fiscal 2000, Medicaid payments to rehabilitation hospitals in Maryland totaled \$6.42 million for 7,471 days of service; Medicaid payments to chronic hospitals in Maryland totaled \$33.8 million for 53,612 days of service. For chronic hospital services, in fiscal year 2000, services were provided in 7 of the 8 licensed chronic hospital units in Maryland facilities.

Fiscal Year 2001 was the twenty-fourth year of the "Medicare Waiver" for hospital services in Maryland, under which the Maryland Medical Assistance Program, Medicare, and other payers reimburse Maryland hospitals according to rates approved by the Maryland Health Services Cost Review Commission ("HSCRC"). The Medicaid Program participates in this system by means of a specific waiver granted by HCFA. The waiver has been renewed on the condition that the State meets certain criteria, the most important of which is that the State reimburse hospitals a lesser amount under the waiver than it would reimburse using Medicare's reimbursement system. Another criteria is that all payers only reimburse for hospital services according to approved HSCRC rates. The HSCRC-approved rates are prospectively determined, and are constructed so that the Program assumes a portion of each participating hospital's bad debt based on its Medicaid utilization.

According to an analysis provided by DHMH, the Medicaid Program's average per diem payment for rehabilitation hospital services was \$859.69 in fiscal year 2000<sup>50</sup>. This average per diem represents an increase of 1.66 percent from the fiscal year 1999 average of \$845.65. With regard to chronic hospital care, the Medicaid Program's average per diem payment was \$631.20 for 2000, an increase of 10.88 percent from the fiscal year 1999 average of \$569.29<sup>51</sup>.

## ? **Community and Public Health Administration**

To insure that basic public health services are provided in all parts of Maryland, the Community and Public Health Administration oversees the local health departments in each county and Baltimore City. Under the direction of a local health officer, each local health department provides these services and administers and enforces state and local health laws and regulations in its jurisdiction. Programs are intended to address the public health needs of the community, and provide services not offered by the private sector. The local health officer is appointed jointly by the Secretary of Health and Mental Hygiene and the local governing body.

Under this Administration are Maryland's local health departments, Deer's Head Center and Western Maryland Center<sup>52</sup>. The Administration is organized into four main teams:

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<sup>50</sup> FY 2000 is the latest year complete Medical assistance data are available.

<sup>51</sup> This does not include data for Kennedy Krieger Institute or Mt. Washington Pediatric Hospital, specialty pediatric rehabilitation hospitals. In FY 2000, these two facilities received a total of \$7,181,800.24 in payments from Medicaid for 6,693 days of service. The average per diem rate was \$1,073.03. In 1999, Medicaid paid these two specialty pediatric hospitals \$6,193,371 for 5,956 days of service with a per diem rate of \$1,039.85. The fiscal year 2000 average per diem rate represents an increase of 3.19% from the fiscal year 1999 average per diem rate.

<sup>52</sup> The Directors of both DHC and WMC report directly to the Director of the Community and Public Health Administration.

Administrative, Policy and Management Support, Consumer Health and Facility Services, Family Health Services and Primary Care, and Prevention and Disease Control.

Under the CPHA team of Prevention and Disease Control, the Office of Injury and Disability Prevention (“OIDP”) coordinates Maryland’s public health response to preventing the more than 35,000 annual hospitalizations of Marylanders due to intentional and unintentional injuries. The focus of OIDP is to reduce death and disability due to these incidents. Major initiatives include:

- | Developing and maintaining injury and disability surveillance systems
- | Providing funds for local injury prevention intervention programs
- | Evaluating injury and disability prevention programs
- | Educating the public, professional, and decision-makers
- | Recommending and supporting state and local legislative efforts to reduce injuries

The OIDP brings scientific research and epidemiologic surveillance to bear on a wide variety of pressing injury-related events. The OIDP gathers data on numbers, nature, and risk factors of injuries occurring in Maryland. For example, with funding by the National Centers for Disease Control and Prevention, the Traumatic Brain Injury (“TBI”) Surveillance Program seeks to decrease the number and severity of TBI injuries and deaths in Maryland by strengthening and expanding TBI surveillance activities. The Surveillance Program collects Maryland statistics on incidences, severity, and outcome of traumatic brain injuries. The Disabled Individuals Reporting System (“DIRS”) is notified by hospitals when an individual is discharged with a potentially disabling condition. Additionally, DIRS ensures that such individuals are provided with information and referrals to prevent residual disability. Collaborating institutions include the National Study Center for Trauma and EMS at the University of Maryland at Baltimore and the Johns Hopkins School of Hygiene and Public Health.

TBI is the leading cause of injury-related death in Maryland and nationally, with an estimated 1.9 million Americans experiencing TBIs each year. About one half of these cases result in at least short-term disability, and 52,000 people die as a result of their injuries. The direct medical costs of treatment of TBI are estimated at more than \$4 billion annually.<sup>53</sup>

Other recent program efforts of OIDP have included a community-based residential smoke detector installation project, a comprehensive population-based effort to increase seat belt use in high risk communities, an examination into the most successful use of bicycle helmets, and establishing a statewide firearms-related injury surveillance system.

Ongoing activities of OIDP are designed to increase awareness of prevention opportunities and resources among practitioners and the general public.<sup>54</sup> The goal of all these activities is to prevent or reduce injuries requiring the use of either rehabilitation hospital or chronic hospitals services.

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<sup>53</sup> [www.mdpublichealth.org/oidp](http://www.mdpublichealth.org/oidp)

<sup>54</sup> Ibid.

## ? **Health Professionals Boards and Commissions**

The purpose of the Health Professionals Boards and Commissions is to ensure that the highest quality health care is provided to the residents of Maryland. The Health Professionals Boards and Commissions issue licenses to practice in the State of Maryland, and also investigate complaints and take disciplinary action against licensees when necessary. Both health professionals and consumer members serve on the boards, which follow the ethical guidelines and standards of the profession they regulate. Another function of the Health Professionals Boards and Commissions is to promote knowledge and performance of goals for professionals that concern the citizens of the State of Maryland.

One health occupation board, the Board of Physician Quality Assurance (“BPQA”), is the State agency authorized to license physicians and certain other health care professionals such as physician assistants, cardiac rescue technicians and medical radiation technologists in Maryland. In addition to establishing qualifications for licensure, the BPQA is responsible for investigating complaints against licensed professionals and for taking action against the licensure of those who violate Maryland’s standards of medical care delivery, including care delivered by medical professionals delivering care in rehabilitation and chronic hospitals.

The missions of other boards, such as the Board of Nursing, the Board of Social Workers, and the Board of Pharmacy, are charged with protecting the people of Maryland through licensure, certification, and other regulations governing the scope and details of each health occupation’s practices. Since inpatient rehabilitation services and chronic hospital services are based on a multi-disciplinary team approach to care, nurses, social workers, and pharmacists often work closely with physicians as the primary health care providers of rehabilitation and chronic hospital services.

## ? ***Maryland Insurance Administration (“MIA”)***

The Maryland Insurance Administration (“MIA”) provides for the licensure of insurers and agents; establishes financial and capital standards for insurers of all types, and sets requirements for rate making and disclosure, and for fair practices. The MIA handles consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs or insurers. The Administration’s Division of Life and Health is responsible for regulating life, health (including long-term care), HMO, annuity, and dental plan insurance lines.

In an effort to provide customer information in the area of health insurance, including services provided in rehabilitation hospitals and chronic hospitals, the Maryland Insurance Administration publishes a series of publications including the following:

Health Insurance for Small Businesses—Rate Comparison Guide This guide provides a comparison of premiums for the Comprehensive Standard Health Benefit Plan for all health insurance companies using a model group.

Consumer’s Guide to Health Insurance in Maryland This publication provides information about health care coverage, including an explanation of how health insurance works,

types of health insurance available, shopping tips, options if consumers cannot afford health coverage, how to file a complaint, and frequently asked questions.

Additionally, the MIA distributes the following health insurance-related publications produced by federal agencies or the National Association of Insurance Commissioners (“NAIC”):

NAIC Shoppers Guide to Long-Term Care which assists consumers in understanding long-term care and the insurance options that can help pay for long-term care services.

Guide to Health Insurance for People with Medicare which offers assistance in the purchase and use of Medicare supplemental, or Medigap, insurance. The guide also includes information on other kinds of health insurance (i.e. group insurance, retiree coverage, etc.) and long-term care insurance, and is produced annually by the Health Care Financing Administration.

### ? ***Office of the Attorney General***

The Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General has the authority to handle consumer complaints against providers of rehabilitation hospital and chronic hospital services which involve billing, contractual or reimbursement issues. The unit refers quality issues to the Office of Health Care Quality.

### ? ***Maryland Health Services Cost Review Commission***

The Health Services Cost Review Commission (“HSCRC”) is empowered by Health-General Article §19-216 to review and approve the rates and costs of hospitals in Maryland. Its jurisdiction includes nonfederal acute general hospitals, non-governmental chronic hospitals, and private psychiatric hospitals. In addition to establishing a uniform accounting and reporting system, the HSCRC develops rate-setting policies and methodologies to carry out its functions.

As noted above, Maryland is the only state in the nation with a rate-setting system that functions as an alternative to the federal Medicare prospective payment system, as provided in . Section 1814(b) of the Social Security Act. The federal government reimburses waived facilities in Maryland for hospital services provided to Medicare patients on the basis of rates set by the Health Services Cost Review Commission rather than its own payment system. The federal government also accepts the hospital rates set by the HSCRC with regard to federal financial participation in the Maryland Medical Assistance Program (Maryland Medicaid) for hospital services. In this “all-payer” system, hospitals may not grant discounts to any other payers unless the HSCRC has approved them; the HSCRC has allowed only limited discounts for some insurers.

Maryland’s waiver test is based on a comparison of average rates of increase in Medicare Part A payments per admission between Maryland and the rest of the country as a whole. Good performance on the test will reflect improvements in controlling Medicare payments under the

federal perspective payment system. The impact of rehabilitation beds on the waiver will vary depending on the facility's status, that is, whether or not it is included in the test. For example, HealthSouth Chesapeake Rehabilitation Hospital is defined as a freestanding rehabilitation hospital under Medicare, and Medicare payments for inpatient services at this facility are excluded from the Maryland Waiver. Likewise, new rehabilitation hospital beds, such as the 55-bed Kessler-Adventist Rehabilitation Hospital are not under the Medicare waiver.<sup>55</sup>

### **Maryland Health Care Commission**

Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval.<sup>56</sup> Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may propose, such as increases in bed or service capacity, capital expenditures, or expansion into new service areas.

It is important to recognize that the former Maryland Health Resources Planning Commission did not initially have a State Health Plan chapter or standards for CON focused on inpatient rehabilitation services or chronic hospital services at the time it was established in statute in 1982. The following two timelines show the evolution of the State's planning and policy history relating to inpatient rehabilitation services and to chronic hospital services.

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<sup>55</sup> The following rehabilitation hospitals in Maryland are included in the Medicare Waiver: Western Maryland: Memorial Hospital of Cumberland, Washington County Hospital; Southern Maryland: Laurel Regional Hospital; Central Maryland: Deaton Specialty Hospital, Good Samaritan Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, Kernan Hospital, Levindale Hebrew Geriatric Center and Hospital, Maryland General Hospital, Sinai Hospital, and Union Memorial Hospital.

<sup>56</sup> The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefits on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. With regard to nursing-home level care, Maryland's Comprehensive Standard Health Benefit Plan for Small Businesses currently includes a "skilled nursing facility care" benefit characterized as "100 days as an alternative to otherwise covered care in a hospital or other related institution, i.e. nursing home," which carries "a \$20.00 co-payment or applicable coinsurance, whichever is greater."



## **Rehabilitation Hospitals in Maryland**

### **Timeline: 1984 to the Present**

- 1984      The Maryland Health Resources Planning Commission (“MHRPC”) appoints the Task Force on Rehabilitation Services to provide recommendations on key issues related to planning for the development of a system of rehabilitation services in Maryland.
- The MHRPC Task Force presents its preliminary recommendations to the Maryland General Assembly’s Special Joint Subcommittee on Trauma Care Rehabilitation, and to persons attending a conference titled “Developing State Legislative Policy Options for Rehabilitation.”
- 1985      The Task Force on Rehabilitation Services submits its final recommendations to the MHRPC. The group advises that comprehensive and specialized rehabilitation programs in Maryland should be subject to new requirements for special designations by State licensure and accreditation by the Commission on Accreditation of Rehabilitation Facilities (“CARF”).
- 1986      Chapter 733 adds language to the Health-General Article, Annotated Code of Maryland, requiring comprehensive rehabilitation facilities in Maryland to obtain CARF accreditation and State licensure. A hospital shall be classified as a special rehabilitation hospital before the hospital may provide or hold itself out as providing comprehensive physical rehabilitation services.
- 1987      The Joint Committee on Administrative, Executive, and Legislative Review grants emergency status to new regulations on comprehensive rehabilitation services at the request of the MHRPC.
- 1988      The MHRPC completes permanent adoption of the regulations, which include provisions to exempt certain rehabilitation facilities from Certificate of Need (“CON”) review. Prior to the effective date of the regulations, the facility must have: (1) obtained and maintained CARF accreditation; (2) received a CON for beds to provide the type of rehabilitative care defined in the regulations; or (3) met the requirements adopted by the Commission for facilities that are not CARF-accredited. For CON review, the Commission adopts a methodology that projects the number of rehabilitation beds needed in a geographic region based on estimates of the number of discharges with the potential to benefit from inpatient rehabilitation, as defined, following inpatient care in an acute general hospital in Maryland.
- Amendments to the Health-General Article add a list of specific medical services in health care facilities to the section requiring that a CON be obtained to establish certain health care facilities under certain circumstances. The definition of “medical service” includes the category of rehabilitation as well as any subcategory of rehabilitation for which need is projected in the State Health Plan (“SHP”). “Health care facility” was defined previously elsewhere in the statute as an inpatient facility that is organized primarily to help in the rehabilitation of disabled individuals, through an integrated program of medical and other services provided under competent professional supervision.

- 1990 The MHRPC publishes updated projections of the number of beds needed for comprehensive and specialized rehabilitation services, using the final data collected by abstracting information from the medical records of inpatient rehabilitation facilities across the nation and provided to the MHRPC. The source of the national data ceases operation.
- 1991 The MHRPC publishes updated projections of needed beds to reflect changes in the number of available beds. The Commission receives a petition requesting that the Commission review and update the State Health Plan to consider a full range of issues.
- 1992 The MHRPC publishes changes in the number of available beds and the net number of needed beds.
- 1994 The MHRPC appoints the Technical Advisory Group on Rehabilitation Services to assist the staff in identifying policy and regulatory issues and provide recommendations for consideration in updating the SHP. The group reports that a number of rehabilitation facilities in Maryland are submitting data to a national data system for medical rehabilitation, established after a trial study in 1986. The MHRPC Technical Advisory Group provides recommendations that address the continuum of rehabilitation services.
- 1996 The MHRPC updates the State Health Plan to focus on freestanding hospitals and distinct units that provide acute inpatient rehabilitation, and to consider the impact on the utilization of those facilities resulting from strategies to control costs. In the absence of uniform data on discharges from rehabilitation facilities in Maryland and the nation, the amendments delete the methodology to project need. The Commission adopts occupancy rates as a measure of the efficient use of the existing rehabilitation beds in each region of the state.
- 1999 The enactment of House Bill 995 (Chapter 702, Annotated Code of Maryland) integrates and consolidates certain regulatory responsibilities and duties of the Health Care Access and Cost Commission and the MHRPC under the Maryland Health Care Commission ("MHCC").
- 2001 The MHCC adopts technical amendments to update the State Health Plan. The MHCC determines that all rehabilitation facilities in Maryland now report discharge data to the Uniform Data System for Medical Rehabilitation, to which a large number of rehabilitation facilities in the United States and several other countries subscribe.

## **Chronic Hospital Services in Maryland**

### **Timeline: 1988 – present**

- 1988            This marks the beginning of the Maryland Health Resources Planning Commission's regulation of chronic hospital services. Amendments to the Health-General Article added a list of specific medical services, including chronic care, in health care facilities to the section requiring that a CON be obtained to establish certain health care facilities under certain circumstances.
- May 1989       Commission Staff of the Maryland Health Resources Planning Commission, predecessor to the MHCC, conducted chronic hospital site visits and released a summary report that identified the dearth of chronic hospital data.
- 1990            Patient-specific chronic hospital data were collected for the first time, using the Maryland Long Term Care Survey conducted by the Maryland Health Resources Planning Commission
- 1992            Maryland Health Resources Planning Commission initiated a study of the State's chronic hospitals in order to gain a greater understanding of the level of care provided by these kinds of facilities.
- June 1992       In order to carry out the Chronic Hospital Study, a Chronic Hospital Technical Advisory Committee ("CH-TAC") was formed in June 1992. The CH-TAC membership included a representative of each of Maryland's eight then-operating chronic hospitals, a representative of the Maryland Hospital Association, as well as a member of Commission Staff. The report, entitled *An Analysis of Chronic Hospitals in Maryland*, was released in December 1993.<sup>57</sup>

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<sup>57</sup> Policy discussions and debates took place in the Summer of 1993 regarding whether Medicaid, in particular, should encourage nursing homes to accept the more complex chronic care patient for a higher reimbursement level—which would still represent a net savings over more costly hospital placement. Nursing home associations, hospital providers, legislators, and DHMH officials engaged in several months of debate over the extent to which medically fragile ventilator-dependent patients could or should be cared for in nursing homes. See "A Victory for Nursing Homes?", Patricia Meisol, *Baltimore Sun*, August 26, 1993, page 1D.

“Certificate of Need” as a regulatory tool has three levels, each initiated by a written notice or letter of intent to the Commission. For confirmation that a Certificate of Need is not required to establish a certain kind of health care facility or service, a person requests a “determination of coverage” by CON requirements. Staff and counsel analyze the proposal according to the Commission’s statute and applicable regulations, and, if CON review and approval is not needed to undertake the project, the Executive Director issues a determination to that effect as the Commission’s designee.

Proposed new health care facilities and specified actions by existing facilities that do require CON approval come to the Commission either in response to a schedule regularly published in the *Maryland Register*, or, if no schedule has been published for a particular service, as an unscheduled review. Procedural rules dictate how unscheduled reviews must be administratively handled so as to permit a comparative review for the new service, if that is appropriate or practical. The CON review itself proceeds according to additional rules set forth at COMAR 10.24.01, evaluates an application against all applicable standards and need projections for the service in the State Health Plan, and applies six general review criteria related to the need for, and the likely impact of, the proposed project on the health care system. Statute requires that staff (or a Commissioner appointed as a reviewer in a comparative or competitive review) bring a recommendation on a proposed project to the full Commission within 90 days of docketing.<sup>58</sup> The first thirty days after docketing are set aside as a public comment period, in which interested members of the public, as well as “interested parties” in the legal sense, may comment on the proposal or, if they meet criteria in regulation, enter the review in opposition to the project.

Since 1985, health planning statute has permitted the Commission to find, “in its sole discretion,” that certain actions by existing health care facilities -- if the facilities proposing them are merging, or have merged and are proposing to further consolidate or to reconfigure their bed capacity or services – may be exempted from the Certificate of Need requirement that would otherwise apply. This so-called “exemption” from the CON requirement may be granted through action by the Commission for several kinds of actions proposed “pursuant to a consolidation or merger” of two or more health care facilities, if the proposed action:

- Is “not inconsistent with” the State Health Plan<sup>59</sup>;
- “Will result in the delivery of more efficient and effective health care services”; and
- Is “in the public interest.”<sup>60</sup>

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<sup>58</sup> Docketing is the formal start of a CON review; the time period in which a recommendation is to come to the full Commission is 150 days, if an evidentiary hearing is held. However, 1995 legislation to streamline the CON review process mandated the adoption of regulations that restrict evidentiary hearing to those cases in which the “magnitude of the impact” of a potential new facility or service merit the additional time and transactional cost.

<sup>59</sup> “Or the institution-specific plan developed and adopted by the Commission,” pursuant to its authority at Health-General Article §19-122, Annotated Code of Maryland.

<sup>60</sup> Health-General §19-123(j)(2)(iv).

A merged asset system seeking such a finding by the Commission must provide notice of its intent at least 45 days before it requests action on the proposal. Additional procedural regulations (at COMAR 10.24.01.04C) require the Commission to provide notice to the public, with the opportunity to comment on the proposed action.

## ? **Market Entry**

Entry into the market for proposed new inpatient rehabilitation or chronic hospital facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of “medical services” subject to CON if established by an otherwise-regulated health care facility.<sup>61</sup> As with all Certificate of Need review in Maryland, the analysis of applications for CON approval for new facilities or expanded bed capacity<sup>62</sup> in either of these two “special hospital” services evaluates how proposed projects meet the applicable standards and policies in the State Health Plan, and how they address the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.08G(3).<sup>63</sup>

The State Health Plan rules and standards that are applied to CON reviews of proposed new facilities or expansions fall into several distinct categories, including:

- **docketing standards**, which determine whether applications for new facilities or expansions will be accepted and may be docketed for review;
- **review standards**, which are applied to all applications, and provide a composite description of what the Commission has established -- through its staff research, deliberation, and the public adoption process -- should characterize a facility or service of the kind under review;
- **approval rules**, which set threshold standards that must be met, or a proposed project may not be recommended for Commission approval; and
- **modification rules**, which guide the review of certain kinds of changes proposed to projects already granted Certificate of Need approval.

The State Health Plan chapters that govern the review of CON for new or expanded inpatient rehabilitation services (COMAR 10.24.09) and chronic hospital services (specific provisions within COMAR 10.24.08, the State Health Plan for Long Term Care Services) have an important attribute in common. Instead of establishing a prospective, population-based need

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<sup>61</sup> Cross-reference the footnote that lists the and gives cite????

<sup>62</sup> Bed increases in either service may be authorized by the Commission without CON review through the statutory “waiver bed” rule that permits increases of 10 beds or 10% of total beds, whichever is less, two years after the last change in licensed capacity.

<sup>63</sup> In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant’s compliance with the terms and conditions of any previous CONs; and (6) “provide information and analysis” on the “impact of the proposed project on existing health care providers in the service area.”

projection formula as a barrier to the consideration or approval of new bed or service capacity in these two services, these Plan chapters establish an occupancy threshold, which, if met, enables the Commission to consider and approve new capacity.

For inpatient rehabilitation facilities, the Plan establishes a docketing threshold for each region, based on the licensed bed capacity that currently serves the region. COMAR 10.24.09C(1) states that the Commission will docket a CON application for new or expanded services only if:

- “all CON-approved and CON-exempt rehabilitation beds in the regional service area are available for use, and
- every acute inpatient rehabilitation hospital and unit in the regional service area has maintained, on average, an occupancy rate equal to or greater than [the applicable minimum occupancy threshold] for the most recent 12-month period shown in the Commission’s data . . . released annually in November.”

These thresholds range from 80 percent in regions with 49 beds or fewer, to 85 percent in regions with between 50 and 99 beds, to 90 percent in regions with 100 beds or more. The same capacity-related regional occupancy thresholds are applied to CON applications to expand an existing inpatient rehabilitation hospital or unit.

Review standards for CON applications to establish new inpatient rehabilitation capacity or to expand existing capacity are tightly focused in the State Health Plan. Applicants are required to “demonstrate ongoing compliance with all federal, state, and local health and safety regulations; to provide documentation that the facility will execute written transfer and referral agreements with organizations capable of “managing cases which exceed its own capabilities” and provide appropriate “alternative treatment programs”; and to commit to abide by a set of rules governing research proposals, if it decides to engage in such activity.

With regard to CON applications to establish new chronic hospital services, the Plan permits Commission approval only if “every chronic hospital in the jurisdiction has maintained, on average, an 85 percent occupancy level or better for at least the latest twelve-month period as shown in the Health Services Cost Review Commission Current Rates Report for the latest fiscal year. The Commission may only approve an expansion of existing chronic hospital capacity if all beds authorized for the facility or unit have been operating at least at 85 percent occupancy for the most recent consecutive 24 months. Only three State Health Plan standards govern CON review of chronic hospital proposals: applicants must agree to accept Medicare and Medicaid as principal sources of payment, must “propose to maintain at least an 85 percent annual occupancy level,” and must support through a detailed quantitative analysis the level of capacity they seek to establish.”<sup>64</sup>

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<sup>64</sup> See COMAR 10.24.08.06C.

? **Market Exit: Closures of Certificate of Need-Regulated Facilities or Medical Services**

Statute requires that the Commission approve a “change in type or scope” of a health care service provided by a regulated health care facility; although expressed as a double negative, the law requires that before “the elimination of an existing medical service” (which includes rehabilitation and chronic care, as well as comprehensive or nursing home care – a service often provided at the same facility as either rehabilitation or chronic care services) a health care facility must obtain a Certificate of Need. The purpose of this CON review is not to deny permission to close a facility, but to pursue the Commission’s “due diligence” in determining the impact on access to these services by the people that depended on the facility, as well as the impact on the remaining facilities in the affected area. In its essence, the review of a CON application to close a facility reverses the process and the questions that shape CON review for new capacity.

With regard to both inpatient rehabilitation and chronic care beds and services, if this capacity is a separately licensed unit in an acute general hospital, then new provisions of law enacted in 1999 apply to a proposed closure.<sup>65</sup> No Certificate of Need is required to close a medical service, or indeed an entire hospital, in a jurisdiction with three or more hospitals: Baltimore City, and Baltimore, Montgomery, and Prince George’s Counties. The hospital or hospital system is required to file written notice of its intent to close the service with the Commission at least 45 days before the closure, and within 30 days of that notice, it must hold a public informational hearing in the county where the affected hospital is located, in consultation with the Commission.

In all other counties in Maryland, the law governing proposals to close a medical service, or an entire hospital, remains what it has been since 1985 and the enactment of that year’s package of health care cost containment legislation. A hospital or hospital system in those jurisdictions also must provide notice 45 days before an intended closure,<sup>66</sup> and receive approval by the Commission of an exemption from Certificate of Need review. The standards applied to this action are similar to those under which all CON exemptions are evaluated: the Commission must find that the proposed closure – in this case of an inpatient rehabilitation or a chronic care unit -- is “in the public interest,” and “not inconsistent with” either the State Health Plan, or any institution-specific plan the Commission may develop under its statutory authority.<sup>67</sup>

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<sup>65</sup> HB 994, Chapter 678, Acts 1999.

<sup>66</sup> Commission regulations at COMAR 10.24.01.04D also require hospitals in these jurisdictions to hold public informational hearings in the affected area, also in consultation with the Commission; this is one of several measures in this regulation to provide public notice of proposed facility and service closures where fewer such services exist.

<sup>67</sup> Health-General Article §19-123 (1)(2). The administrative flexibility and relatively simple procedures available to hospitals and health systems that seek to close a facility or a medical service such as inpatient rehabilitation or chronic care do not automatically apply to other kinds of facilities – such as nursing homes – in which some number of chronic care beds may be located. The State-operated chronic care units may be interpreted to fall within the closure provision governing hospitals in counties with three or more hospitals, since that provision also includes “a State hospital.” §19-123 (1)(1).

#### **IV. MARYLAND CERTIFICATE OF NEED REGULATION FOR REHABILITATION HOSPITAL AND CHRONIC HOSPITAL SERVICES COMPARED TO OTHER STATES**

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Thirty-six states, as shown in the latest national directory published by the American Health Planning Association (“AHPA”), have Certificate of Need review for some number of health care facilities and proposed expansion of service capacity. Maryland ranks in the lower third of what the AHPA calls its “Relative Scope and Reviewability” ranking which lists the CON states in descending order, beginning with those with the most covered services and lowest capital and service review thresholds.

In an effort to learn what other states are doing with regard to the regulation by means of a Certificate of Need program of either acute inpatient rehabilitation hospitals or chronic hospitals, Commission Staff contacted other states by means of electronic mail communication through an internet forum established by the American Health Planning Association. Through this forum, Staff received a total of twelve responses from staff from other states’ health planning units.

The State of Vermont has no specific standards for the review of rehabilitation services in hospitals other than the more general standards established in its CON guidelines. Regarding what Vermont –and the federal Health Care Financing Administration – term “long-term acute” services (and what Maryland, under its unique Medicare Waiver, terms chronic hospital services), Vermont has not established a specific licensing category for dealing with that type of service. Most hospitals in Vermont have “swing beds” which serve that long-term acute (chronic) purpose to some degree.<sup>68</sup>

Staff from the Hawaii State Health Planning and Development Agency referred Commission Staff to its website. According to Hawaii’s Certificate of Need Rules, the addition or deletion of any standard category of health care service (including rehabilitation and long-term care [defined as those inpatient services provided to patients who are chronically ill, aged, disabled, or retarded, and whose average length of stay is usually 30 days or more] is a change of service that requires a CON. Further, if a health care facility proposes the addition or deletion of a health care service that is not clearly included in one of the standard categories, the agency shall determine whether or not the change is a change of service that requires a Certificate of Need.<sup>69</sup>

Staff from the State of Illinois responded that Illinois regulates rehabilitation beds as a category of service. A review of the Illinois regulations on rehabilitation hospitals reveals that there is a specific review criterion on facility size for comprehensive physical rehabilitation. The minimum freestanding facility size for comprehensive physical rehabilitation is 100 beds. The minimum hospital unit size for comprehensive rehabilitation is 15 beds. Moreover, there is a

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<sup>68</sup> Electronic mail communication from Stan Lane, State of Vermont, Vermont Division of Health Care Administration, April 13, 2001

<sup>69</sup> Electronic mail communication from Marilyn A. Matsunaga, Hawaii State Health Planning and Development Agency, April 12, 2001, and [www.shpda.org](http://www.shpda.org). Chapter 186, Certificate of Need Rules, Title 11.



statewide need projection for rehabilitation beds. If all beds are taken, applicants can still obtain beds if they can document any of the following exist:

- ? the absence of the service within the planning area;
- ? limitations on governmentally funded or charity patients;
- ? restrictive admission policies of existing providers; or
- ? the project will provide service for a portion of the population who must currently travel over 45 minutes to receive service.

The applicant must also document that the number of beds proposed will not exceed the number needed to meet the health care needs of the population identified as having restricted access at the target occupancy rate.<sup>70</sup>

Staff from the State of Nebraska commented that Nebraska has no regulations, but does have law related to inpatient rehabilitation and what it terms “long-term care” beds. From the definition within the statute for Nebraska “a long-term care bed means a bed that is, or will be licensed as, a skilled nursing facility, intermediate care facility, nursing facility, or long term care hospital bed. Long term care beds do not include residential care beds, domiciliary beds, or swing beds”.<sup>71</sup> Both initial establishment of either of these categories of beds, and an increase of more than ten beds or more than ten percent of total bed capacity over a two-year period, require a Certificate of Need.<sup>72</sup>

Further, all CON-regulated rehabilitation beds in Nebraska are currently subject to a moratorium, except under the following condition: if the average occupancy for all rehabilitation beds located in Nebraska has exceeded ninety percent occupancy during the most recent consecutive three calendar quarters as reported at the time of the filing of the application, the department may grant an exception to the moratorium and issue a CON. If the Nebraska Department of Health and Human Services determines that the average occupancy for all rehabilitation beds located in Nebraska does not exceed ninety percent occupancy during the most recent three consecutive calendar quarters, as reported at the time of the filing of the application, the department must deny the application. Long-term care beds are also subject to a moratorium unless certain occupancy-related exceptions are in place at the time of the filing of an application.<sup>73</sup>

Florida responded that it reviews both acute inpatient rehabilitation (comprehensive medical rehabilitation) and long-term care hospitals. It does not have a need methodology, allocated service areas, or planning horizons for CON regulation for long-term care hospitals. Under its Administrative code, Florida does have a rule it applies to review long-term care (chronic hospital) applications. If there is no need methodology, applicants are responsible for demonstrating need through a methodology that includes, at a minimum, the following:

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<sup>70</sup> Electronic mail communication from Mike Copelin, Illinois Department of Public Health, April 12, 2001 and telephone contact April 25, 2001.

<sup>71</sup> 1999 State of Nebraska, Statutes Relating to Health Care; Certificate of Need Health Care Facility-Provider Cooperation, Nebraska Health and Human Services, Credentialing Division, p.1.

<sup>72</sup> Ibid, p. 3.

<sup>73</sup> Ibid.

- a) Population demographics and dynamics;
- b) Availability, utilization, and quality of like services in the district, sub-district, or both;
- c) Medical treatment trends; and
- d) Market conditions.

Florida has considered the service area as something larger than its “districts”, though in a recent review, it only looked at the district.<sup>74</sup>

Staff from the State of Alaska commented that although it has the authority to review these types of services, Alaska has such a small population base that no specialized hospitals for rehabilitation or chronic hospital services have ever been developed, so there are no standards for them.<sup>75</sup>

In Missouri, for new acute rehabilitation services, the state’s population-based standard is one bed per 9090 population and existing units in the service area must have an 80% occupancy rate. Small units may be developed under the 10 bed, 10 percent provision, or even larger units may be established as long as they do not exceed the applicable expenditure minimums.

For Missouri, chronic hospital services are different. These services, according to the federal regulations, must be in separately licensed facilities. All such beds in Missouri are subject to CON review regardless of cost. Furthermore, they are subject to the restrictions placed on additional, long term-care beds. If the occupancy of skilled nursing and intermediate care beds within the county and 15-mile radius of the proposed chronic facility have not exceeded 90% for each of the four most recent calendar quarters, any application for additional chronic beds would be automatically denied.<sup>76</sup>

Oregon’s CON program does review new hospitals, but not new hospital services at existing hospitals, if those services are something that the hospitals can provide under their existing type of hospital license. According to staff at the Oregon CON Program, that state does not have any “long-term acute care hospitals”. If Oregon did get such an application, it would be subject to CON review. Although Oregon does have rules that govern the creation of hospitals generally, an application for chronic hospital (or as Oregon terms it, “long-term care” services) would necessitate the state’s adopting administrative rules to address this type of facility.<sup>77</sup>

Michigan’s CON division regulates hospital acute care inpatient (medial/surgical) beds that also can be used as rehabilitation beds, as well as long-term care beds (i.e., nursing home and hospital long-term care unit beds).<sup>78</sup>

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<sup>74</sup> Electronic mail communication from Karen Rivera, Florida Department of Health Care, April 12, 2001

<sup>75</sup> Electronic mail communication from David Pierce, Alaska Health Department , April 12, 2001.

<sup>76</sup> Electronic mail communication from Mike Henry, Missouri State Health Department, April 13, 2001

<sup>77</sup> Electronic mail communication from Jana Fussell, Department of Human Services, Oregon Health Division, Certificate of Need Program, April 13, 2001

<sup>78</sup> Electronic mail communication from Catherine Stevens, Michigan State Health Department, April 13, 2001

Staff from the South Carolina Department of Health and Environmental Control responded with a copy of a draft of the 2001 South Carolina Health Plan which contains Certificate of Need Standards for Rehabilitation. As of November 1, 2000, the need for rehabilitation beds is calculated based on 12 service areas as defined in the Plan. An occupancy factor of 75% was used to calculate projected bed need. The greater of the service area's actual utilization, or 75% of the statewide use rate, was used to project bed need. Due to the low utilization of existing hospital beds in South Carolina, state policy requires that consideration be given to the conversion of existing hospital beds to rehabilitation beds, rather than to the construction of new facilities and/or beds.

With regard to chronic hospitals (what South Carolina terms "long-term care" hospitals), these may either be a freestanding facility, or may occupy space in a building also being used by another hospital or in one or more buildings located on the same campus as buildings being used by another hospital. There are currently four long-term care hospitals in South Carolina.

In South Carolina, the standards for CON for chronic (long-term care) hospitals are as follows:

1. An application for Long-Term Care Hospital must be in compliance with the relevant Licensing Standards for Hospital and Institutional General Infirmaries (Regulation No. 61-16)
2. Long-Term Care Hospital beds will not be considered as a separate category for licensing or planning purposes. All long-term care beds remain part of the inventory of general acute care hospitals beds.
3. Approval will only be given for the conversion of existing licensed general acute care beds to long-term care beds. Projects which involve the construction of new health care facilities will not be approved.<sup>79</sup>

However, according to Albert N. Whiteside, III, Director, Division of Planning and Certification of Need, a CON is not required for a long-term care hospital if the entire hospital becomes a long-term care hospital. South Carolina has one such 62-bed facility in Spartanburg.<sup>80</sup>

Staff from the Iowa Department of Health report that Iowa does not recognize "specialty hospitals". Therefore, no Certificate of Need regulations exist for dealing with the specialties of acute inpatient rehabilitation hospitals or chronic hospitals.<sup>81</sup>

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<sup>79</sup> Electronic mail communication from Albert Whiteside, III, Director, South Carolina Division of Planning and Certification of Need, April 17, 2001.

<sup>80</sup> Telephone contact with Albert Whiteside, III, Director, South Carolina Division of Planning and Certification of Need, April 26, 2001.

<sup>81</sup> Electronic mail communication from Barb Nervig, Certificate of Need Program Iowa Department of Public Health, April 24, 2001.

Staff from the Department of Health for the State of New Jersey report that New Jersey has a current Certificate of Need rule for inpatient comprehensive rehabilitation care which contains a formula-based need methodology that is region specific. With respect to what New Jersey terms “long term acute care hospitals,” and what Maryland terms chronic hospitals, New Jersey has none. New Jersey is in the process of drafting both Certificate of Need and licensing standards for this service, however.<sup>82</sup>

These electronic mail communications represent one third of the number of states which have CON in some form. Additionally, contact with staff of the American Health Planning Association indicates that applications for acute inpatient rehabilitation hospitals and chronic hospitals are subject to CON review in the states of New York, Virginia, and West Virginia.<sup>83</sup>

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<sup>82</sup> Electronic mail communication from A. Kobylarz, State of New Jersey, Department of Health, May 3, 2001.

<sup>83</sup> Electronic mail communication from Dean Montgomery, American Health Planning Association, April 13, 2001.

## **V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS**

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The options discussed in this section represent alternative strategies governing oversight of acute inpatient rehabilitation hospital and chronic hospital services in Maryland. Each of these services is considered separately, with its potential alternative regulatory frameworks taken up separately.

The role of government in these options describes a continuum varying from the current role (Option 1), to a more expanded role (Options 2 and 3), to an extremely limited role (Option 6). The options below, singly or in combination for either service, suggest potential alternative strategies that could be considered in relation to the larger issue of how Maryland should regulate rehabilitation hospital and chronic hospital services. As with the options presented by the staff Working Papers during Phase 1, this is not an exhaustive list of options. The Commission expects other options and ideas to be generated through the public comment process.

### **A. REHABILITATION HOSPITALS**

#### **OPTION 1: Maintain Existing Certificate of Need Review Program Regulation for Rehabilitation Hospital Beds**

This option would maintain the CON review requirement for new or expanded rehabilitation hospital services in current law and regulation. Under current law, establishing a new rehabilitation hospital service, or expanding an existing service, requires a CON. The Commission's decision on a given application is based on its review of a proposed project's consistency with the State Health Plan's review standards and minimum occupancy requirements based on licensed capacity of the regional service area, and the general CON review criteria. To exit from this market, only a written notification of the intended closure of a rehabilitation hospital service is required in a county with 3 or more hospitals; CON exemption by Commission action is required in all other jurisdictions.

#### **OPTION 2: Re-establish Need Thresholds for Rehabilitation Hospital Beds**

There is no current bed need projection methodology for rehabilitation hospital services. This option would involve changing the policies and regulations in the State Health Plan chapter on Specialized Health Care Services – Acute Inpatient Rehabilitation Services at CPMAR 10.24.09 by re-introducing a bed need projection methodology to project need for inpatient rehabilitation services on a regional basis. Currently, the SHP chapter indicates that the Commission will docket a CON application for new or expanded services only if all CON-approved and CON-exempt rehabilitation beds in the regional service area are available for use, and every acute inpatient rehabilitation hospital and unit in the regional service area has maintained, on average, an occupancy rate equal to or greater than specified appropriate

minimum occupancies for the most recent 12-month period shown in the Commission's data on rehabilitation occupancy rates to be released annually in November. Additionally, the Commission will approve an acute inpatient rehabilitation hospital or unit for expansion provided all its beds are available for use and it has been operating at, on average, an occupancy rate equal to or greater than specific appropriate minimum occupancy for the most recent 12-month period shown in the Commission's data on rehabilitation occupancy rates to be released annually in November.

The current use of the occupancy threshold allows for a more immediate response on the part of providers to what they are currently experiencing in their facilities, whereas a need methodology may be less flexible, requiring providers await the projection of need by the Commission before they could submit an application for new or expanded services.

### **OPTION 3: Deregulate Rehabilitation Hospital Beds from Certificate of Need Review, With Approval by the Medicaid Program of Any New Rehabilitation Hospital Beds and Facilities Seeking Medicaid Reimbursement**

Some states that discontinued their Certificate of Need programs in the early 1980s have, in effect, substituted a barrier to market entry for some kinds of health care facilities—specifically, for any proposed new facility or proposed expansion in nursing home bed capacity at an existing facility, where that facility will seek (or already receives) reimbursement from the Medical Assistance Program. In Maryland, since the cost of capital construction as well as operating costs are factored into the rates Medical Assistance pays to health care facilities to care for its recipients, the prospective impact on the state's Medicaid budget of new facilities or beds would seem to create general consensus that controlling health care facility capacity - including rehabilitation hospital capacity - is necessary and important.

In Arizona, for example, health services for residents receiving state funded health care are managed by HMOs. A regional HMO has the authority to reject applications by proposed new facilities, whether hospitals or nursing homes, to become new providers in the state funded system.<sup>84</sup> To the extent that a proposed rehabilitation hospital or unit would depend on payments by Medical Assistance to support its patient base, its operations, and its initial construction, this option could present a considerable barrier to market entry. Under this option, too, while the Medical Assistance Program could assume the responsibility for conducting reviews for proposed new Medicaid providers for rehabilitation services, the need for objective standards by which to conduct such reviews – and the expertise in conducting quantitative analysis of the need for a new rehabilitation facility or bed capacity – may suggest that the Commission should continue as the reviewing authority, at least initially.

### **OPTION 4: Impose a Moratorium on New Rehabilitation Hospital Beds**

A significant number of states have imposed a moratorium on beds for new health care facilities, or expansion of existing health care facilities, including beds for inpatient rehabilitation hospitals. This effort is seen as an administratively simple and definite way of limiting the

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<sup>84</sup> Conversations with Paul Shafer of the Arizona Office of Health Cost Control, October 2000.

impact on a state's Medical Assistance budget. In a time of severe shortages in direct patient care professionals, from registered nurses to nurses' aides to medical technicians, any expansion of a particular sector of the health care service market – of capacity or of programs – may be problematic. Removal of restrictions on market entry, whether by CON or other means, raises the possibility that supply will increase.

#### **OPTION 5: Deregulation With Enhanced Licensure Standards With and Without Reporting Model to Encourage Quality of Care**

Under this option, the role of government oversight would shift from regulating market entry and exit to monitoring the on-going performance of the service through licensure standards either alone or in conjunction with a mandatory reporting model. Deregulation through elimination of the CON requirement for inpatient rehabilitation hospital services is discussed in Option 6, and the implications of that option apply here. This option supports the role of government to provide information in order to promote quality health services. Performance reports or “report cards”, as they have been called, are intended to incorporate information about quality into decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. As such, report cards may both inform consumer choice and improve the performance of health services.

Regarding licensing standards, currently, inpatient rehabilitation hospitals are licensed in Maryland by OHCQ based on compliance with standards developed by CARF....The Rehabilitation Accreditation Commission and COMAR 10.07.01, regulations for acute and special hospitals. Under the licensure model, there is the implication that non-compliance with standards for inpatient rehabilitation hospital services will result in the potential to lose the license for that service.

This option, similar to other options that remove barriers to market entry and/or exit, could result in hospitals currently without inpatient rehabilitation hospital services seeking to establish this service. Thus, the implications discussed under Option 6 would also apply to this option. On the other hand, under this option there would be greater public policy emphasis placed on performance goals. While the CON process provides a tool for examining quality issues before a provider enters the market, it is not now designed to monitor outcomes on an on-going basis, as is the OHCQ.

A further discussion of public report cards for consumers and provider feedback performance reports is found under Option 5 for Chronic Hospital services.

#### **OPTION 6: Deregulation of Rehabilitation Hospital Beds from Certificate of Need Review**

The effectiveness of Certificate of Need as a means of controlling costs and service capacity, and whether it represents the “best” regulatory tool for the job, has long been debated. This last option, of course, would deregulate rehabilitation hospital services from CON review,

perhaps as a phased-in statutory change, and monitor the impact of this action. Under this option, all CON review requirements related to both market entry and exit would be eliminated, allowing the market to allocate inpatient rehabilitation hospital services, both new services and closures. In the absence of CON review, this option then defers to the oversight of HSCRC, DHMH, OHCQ, MIA, the Health Professionals Boards and Commissions, and the Office of the Attorney General to address issues of cost, quality, and access.

Repeal of CON has been associated with increases in supply in some health care services in several states. Whether this would hold true for inpatient rehabilitation hospital services in Maryland under the existing Medicare Waiver for hospital services is open to question. If this were to happen in Maryland, this could potentially have a negative impact on the Medicare Waiver.

## **B. CHRONIC HOSPITALS**

### **OPTION 1: Maintain Existing Certificate of Need Review Program**

This option would maintain the Certificate of Need program for the establishment of Chronic Hospitals as it is currently designed. Under current law, establishing a new chronic hospital or unit requires a Certificate of Need, based on Commission review of an applicant's consistency with the State Health Plan policies and standards. As for exit from this market, pursuant to HB 994 in 1999, with notification to the Commission, this rule is the same for rehabilitation hospitals and chronic hospitals in acute care. Also, under current law, closing a chronic hospital service requires only notification in multi-hospital jurisdictions. However, Commission approval of a Certificate of Need exemption is required for service closure in one- or two-hospital jurisdictions, to assure that access is not unnecessarily compromised.

### **OPTION 2: Establish a Need Projection for Chronic Hospitals**

Currently, there is no projection of need for chronic hospital services. The Commission will approve a Certificate of Need application for new or expanded chronic hospital services only if every chronic hospital in the jurisdiction has maintained, on average, an 85 percent occupancy level or better for at least the latest 12-month period. The applicant may show evidence as to why this rule should not apply to the applicant. With regard to expansion, the Commission will approve a chronic hospital service for expansion only if all its beds are available for use, and it has been operating at least at 85 percent average occupancy for a period of at least the most recent 24 months.

Under this option, the authority of the Certificate of Need program would cover projections of need and issues related to geographic access, the distribution and quality of services, and financial viability of the proposed provider. Projections of need have helped to identify geographic areas of the State that are underserved. The unmet needs of a population would be the focus of the plan and CON review. Standards would address the availability, accessibility, cost, and quality of services.



### **OPTION 3: Deregulation from Certificate of Need Review, With Approval by the Medicaid Program of Any New Chronic Hospital Beds and Facilities Seeking Medicaid Reimbursement**

As noted in *An Analysis and Evaluation of the CON Program, Phase I*, some states that had discontinued their Certificate of Need programs in the early 1980s have, in effect, substituted a barrier to market entry for some kinds of nursing facilities – specifically, for any proposed new facility or proposed expansion in bed capacity at an existing facility, where the facility will seek (or already receives) reimbursement from the Medical Assistance Program.

Following up on this action, originally applied to nursing facilities, this proposed option would seek to carry it over to chronic hospital services. Since the cost of hospital construction, as well as operating costs, are factored into the rates Medical Assistance pays to hospitals to care for its enrollees, the prospective impact on a state’s Medicaid budget of new facilities or beds has created wide consensus, in CON and non-CON states, that controlling health facility bed capacity is necessary and important.

Again, under this option, while the Medical Assistance program could assume the responsibility for conducting reviews for proposed new Medicaid providers, the need for objective standards by which to conduct such reviews – and the expertise in conducting quantitative analysis of the need for a new chronic hospital facility or bed capacity – would suggest that this Commission may continue as the reviewing authority, at least initially.

### **OPTION 4: Impose a Moratorium on New Chronic Hospital Beds**

According to *An Analysis and Evaluation of the CON Program, Phase I*, a significant number of states, including those which have ended their CON programs, have imposed a moratorium on such services as new nursing homes and new beds, even on replacement projects, as a way of limiting the impact on their state’s Medicaid Program’s budgets. With this model in mind, this option would propose to seek to place a freeze on new capacity for chronic hospital services. However, the experience of the State of Ohio, which has had a moratorium on nursing home beds since 1993, may prove cautionary. Although Ohio’s average occupancy in nursing homes is “in the 80% range”, some “areas and providers with high occupancy could use additional beds.”<sup>85</sup> The only source of these beds for providers is the purchase of operating rights to existing beds from existing providers. However, the moratorium on new beds has led to the inflated purchase price of such beds, and these costs have been passed through to both Medicaid and Medicare.

With the lesson of what has happened in Ohio in mind, this option does not contemplate a moratorium on chronic hospital services without a regular, periodic calculation of chronic hospital bed need. Additionally, the health care environment is so dynamic that it would only be prudent to continue to monitor and analyze its changes.

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<sup>85</sup> Electronic mail communications from Christine Kenney of Ohio’s health planning agency through an internet forum established by Thomas Piper of Missouri’s health planning agency with the encouragement and support of the American Health Planning Association.

### **Option 5: Deregulation With Enhanced Licensure Standards With and Without Reporting Model to Encourage Quality of Care**

Similar to Option 5 for Rehabilitation Hospitals above, under this option, the role of government oversight would shift from regulating market entry and exit to monitoring the ongoing performance of existing licensure standards for chronic hospitals. In addition to the quality of care issues that are traditionally the province of OHCQ, coupled with Medicare certification, this enhanced licensing program could include and enforce some of the standards reviewed for initial compliance under the existing CON review process. Under this regulatory model, through some series of graduated sanctions, prolonged failure to comply with the requirements of State licensure would ultimately result in the loss of the chronic hospital license as well as Medicare certification.

Linked with this option is the addition of either a public report card for consumers for chronic hospital services or provider feedback performance reports.

The public report card would add a chronic hospital services report card to the Commission's growing list of public reports containing basic, service-specific information in a report card style format, with the intent of promoting consumer education and choice. Report cards on Chronic Hospital services could be designed to report on the facilities according to a range of variables including administrative simplicity, availability and expertise of physicians on staff, and accessibility of nurses and other direct care professionals. One potential limitation of the report card model for chronic hospital services is the adequate capturing of subjectively felt values of medically compromised patients who require the chronic hospital level of care.

Under the added option of provider feedback performance reports, either the Commission or another public or contracted private agency, would establish a data collection and reporting system designed for use by providers of chronic hospital services. Like the report card option, this option would involve the mandatory collection of detailed outcomes and process information from all chronic hospital services, in order to measure and monitor quality of care using a selected set of quality measures specific to chronic hospital services. The purpose would be to provide feedback on how chronic hospitals compare to their peers on issues such as staffing and utilization. This option would assume that if providers are fully informed about their performance in relation to their peers, and held more accountable for outcomes of care, they would have sufficient incentive to achieve and maintain a level of high quality care. While the Certificate of Need program, both historically and as it is now constituted, is neither designed nor intended to monitor quality of care once an approved program begins operation, this option does further that goal.

### **Option 6: Deregulation of Chronic Hospital Beds from Certificate of Need Review**

This option would remove Certificate of Need review and approval, and the barrier to market entry or exit. It would defer to the authority and rules of the Maryland Department of Health and Mental Hygiene and its licensing agency, the Office of Health Care Quality, and particularly to those rules and conditions of participation in both Medicare and Medicaid that OHCQ administers on behalf of the federal government. Capacity of beds and facilities would

not be limited by any demographically-and geographically-based formula which the Commission might develop, nor subjected to the initial review of program, staffing levels, and reasonableness of construction costs that would make up the completeness review of an initial application for new or expanded chronic hospital services.

The array of factors that present challenges to the provider of chronic hospital services – State initiatives in response to the *Olmstead* decision, staffing issues, financial constraints – have reduced the incentive to build new chronic hospital capacity. These constraints might argue that no untoward impact would result if chronic hospital services were excluded from the requirement to seek CON approval for new or expanded capacity. This view would argue that the challenges facing the present providers of chronic hospital services are sufficient to discourage new providers, or those from out of state. A contrary view would be that when the health care insurance and reimbursement environment changes, in the absence of a CON requirement, there could be effort to overbuild chronic hospital beds. As a safeguard to this possibility, the Commission can decide to periodically re-evaluate any or all of its various roles in the regulatory oversight of chronic hospital services in Maryland.

Tables 8 and 9 below summarize the policy options discussed in this report.

## VI. SUMMARY

**Table 8**  
**Summary of Regulatory Options for Inpatient Rehabilitation**  
**Hospital Services**

<b>Options</b>	<b>Level of Government Oversight</b>	<b>Description</b>	<b>Administrative Tool</b>
<b>Option 1</b> Maintain Existing CON Regulation	No Change in Government Oversight	?Market Entry Regulated by CON ?Market Exit through Notice-3 or More Hospitals ?Market Exit through CON Exemption Notice-3 or More Hospitals	Commission Decision ("CON")
<b>Option 2</b> Re-Establish Need Thresholds	Change Government Oversight	?Market Entry and Exit Regulated by CON and Exemption ?Market Exit through Notice-3 or More Hospitals ?Market Exit through CON Exemption Notice-3 or More Hospitals	Commission Decision
<b>Option 3</b> Deregulate from CON Review, Medicaid Approval of New Inpatient Rehabilitation Hospital Services	Change Government Oversight	?Market Entry Barrier for Medicaid Certified Beds and Facilities	Medicaid Review and Approval for Beds or Facilities Seeking Medicaid Payment, Based on Medical Assistance Budget
<b>Option 4</b> Impose Moratorium on New Inpatient Rehabilitation Hospital Beds	Change Government Oversight	?Market entry Barred; Changes to Existing Capacity and Market Exit through CON	Commission Decision ("CON")
<b>Option 5</b> Deregulate from CON Review With Enhanced Licensure Standards, With and Without Reporting Model	Change Government Oversight	? No Barrier to Market Entry ?Market Exit for Non-compliance with Licensure Standards	State Licensure Standards; Report Cards
<b>Option 6</b> Deregulate Inpatient Rehabilitation Hospitals from CON Review	Decrease Government Oversight	? No Barrier to Market Entry or Exit by CON Review	State Licensure, Certification Standards

**Table 9**  
**Summary of Regulatory Options for Chronic Hospital Services**

<b>Options</b>	<b>Level of Government Oversight</b>	<b>Description</b>	<b>Administrative Tool</b>
<b>Option 1</b> Maintain Existing CON Regulation	No Change in Government Oversight	? Market Entry Regulated by CON ? Market Exit through Notice-3 or More Hospitals ? Market Exit through CON Exemption-3 or More Hospitals	Commission Decision ("CON")
<b>Option 2</b> Establish Need Projection	Change Government Oversight	? Market Entry and Exit Regulated by CON and Exemption ? Market Exit through Notice-3 or More Hospitals ? Market Exit Through CON Exemption-3 or More Hospitals	Commission Decision
<b>Option 3</b> Deregulate from CON Review, Medicaid Approval of New Chronic Hospital Services	Change Government Oversight	? Market Entry Barrier for Medicaid Certified Beds and Facilities	Medicaid Review and Approval for Beds or Facilities Seeking Medicaid Payment, Based on Medical Assistance Budget
<b>Option 4</b> Impose Moratorium on New Chronic Hospital Beds	Change Government Oversight	? Market Entry Barred; Changes to Existing Capacity and Market Exit Through CON	Commission Decision ("CON")
<b>Option 5</b> Deregulate from CON Review With Enhanced Licensure Standards With and Without Reporting Model	Change Government Oversight	? No Barrier to Market Entry ? Market Exit for Non-compliance with Licensure Standards	State Licensure Standards
<b>Option 6</b> Deregulate Chronic Hospital Beds from CON Review	Decrease Government Oversight	No Barrier to Market Entry or Exit by CON Review	State Licensure Standards